‘Building Space: Developing Reflection for Wellbeing’

Can a chaplain help healthcare professionals develop reflective practice for wellbeing for themselves and their team?

Thesis submitted in accordance with the requirements of the University of Chester for the degree of Doctor of Professional Studies in Practical Theology

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Contents

"The material being presented for examination is my own work and has not been submitted for an award of this or another HEI except in minor particulars which are explicitly noted in the body of the thesis. Where research pertaining to the thesis was undertaken collaboratively, the nature and extent of my individual contribution has been made explicit."

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I pray for anyone who has yet to build space, yet to hear their voice and the voice of others, and yet to be able to tell their story.

Abstract

In this thesis I develop a new, wider and richer understanding of wellbeing, through developing a process of reflective practice, with healthcare professionals within their challenging work culture. As a healthcare chaplain, having witnessed poor staff morale, I conducted a critical examination of NHS wellbeing reports and strategies, which revealed an understanding of staff wellbeing that ironically follows simply a health model. Challenging this, I argue for a broader interpretation of wellbeing that, in addition to focusing on health, is more holistic, relational and contextual. I develop reflective practice to nurture this, the use of which extends in healthcare beyond education and professional development.

In my action research, knowledge was generated through ethnographic participation and observation, over a year, reflecting as chaplain with eight teams of healthcare professionals. This used my simple and memorable HELP Wellbeing Reflection Cycle (building on Kolb's (1984) model of experiential learning) that combines reflection on work and personal development. My project also responds to Rolfe's call (2014) for greater use in healthcare of Schön's (1980) "reflection-in-action". Building on these works, I develop reflection for healthcare professionals to nurture their wellbeing. My encouragement of the participants to self-facilitate their own reflective groups, when familiar with this method of reflection, is also a contribution to reflective practice, healthcare and the chaplain's role.

Thematic data analysis emerged from the reflexive field notes of our shared experience as co-reflective practitioners. The themes include healthcare professionals making the human connection between themselves and with their patients. They also value the space to reflect together, realising their desire for team support and a shared goal, as well as job satisfaction in this demanding culture. These themes, I argue, are consistent with the broader definitions of wellbeing, giving them the opportunity to be both a healthcare professional and human. Further data analysis also reveals consistency with wider wellbeing interpretations (including personal wellbeing measurements and data from the Office for National Statistics (2014, 2015)).

I develop the role of chaplain as the healthcare professionals' co-reflector, sharing their reflective space as a pastoral encounter and a source for learning. This combines the images of "empty handed" (Swift, 2009) "welcoming guest" and "mutual hospitality" (Walton, M., 2012). I offer to national healthcare the wider understanding of wellbeing, and the value of creating provision for reflective space to nurture it, in the care of healthcare professionals. This research offers the potential for exciting further developments in a wider constituency both in and beyond healthcare.

Summary of Portfolio

The portfolio work prior to this thesis shows my study and development through the professional doctorate programme. Having been encouraged to consider my use of reflective practice as a research subject, I had also been asked to help boost morale in a team of healthcare professionals in my work context. Using reflection as part of my professional practice and knowing that healthcare professionals use it in their educational development, I wanted to know if they could adapt its use for their own wellbeing. I had begun to see that, given space to reflect in small groups of colleagues, there was an apparently positive effect on their immediate frame of mind. I wanted to discover if building that space in their work environment would be possible and if, as priest and chaplain, I could empower them to develop using reflective practice to help morale in their daily context.

My literature review explored practical theology, recognizing it as incarnational, in dialogue with experience, the means of discovering transformation and living with change, with theological reflection at its heart. I examined the ways in which reflective practice is used, seeing it in healthcare for education and professional development, and in the Church as a tool for learning and supervision as well as for self-awareness, discernment and journeying. I investigated the role of the healthcare chaplain seeing it as ministry at the heart of profound human experience and living with temporary answers. For my publishable article I designed a pilot study, developed from an audit on which I was working, which generated data to see how reflecting regularly with healthcare professional groups would be received. Through this I began to learn about the qualitative research process. I also explored the healthcare understanding of wellbeing for its staff and found it ironically limited to health but in my reading had found a much broader definition essentially as holistic and relational.

Undertaking the DProf I wanted to argue for healthcare professionals to have space in their daily context to nurture reflection for wellbeing. For the research proposal I developed a methodology and qualitative research design with me as co-reflector and facilitator in reflective practice sessions in their work environment. In the 'reflection on practice' paper I critically analysed this practice and explored the two paradigms of 'creating space' and 'hospitality' from my reading and reflections.

In analysing the data from my research there was a more holistic, relational, contextual understanding of wellbeing in the issues they were reflecting, for example making the human connection, professional challenges, valuing team support and reflective space. My thesis will therefore argue towards developing a reflective praxis to nurture a new wider understanding of wellbeing for healthcare professionals, and the further contribution this brings both to reflective practice, healthcare and chaplaincy.

Abbreviations

NHS National Health Service

HCP healthcare professional(s)

RPW reflective practice workshop(s)

Note

'Well-being' or 'wellbeing'

In either form this is repeated as found when quoting text but in my own writing the preference is 'wellbeing'.

The Thesis Architecture

Building an everyday sanctuary

Deep insights from the ascetics' "desert sanctuary" of the 4th and 5th century were translated by 6th century St. Benedict as the foundation of his vision for monastic living. In the 21st century book, *Finding Sanctuary,* Benedictine Abbot Christopher Jamison develops this, beyond the monastery, for today's busy world. This is because "Our search involves learning how to build a sanctuary in the midst of everyday life" (Jamison, 2006, p.9).

Asking monks to "incline the ear of thy heart" (Benedict, 1976, p.1), Benedict's premise was to call his community to return to the "tabernacle" of God's Kingdom (Benedict, 1976, p.2). This included allying one's own purposes with God's purposes and to grow closer to Him. Seeking such a place within the challenges of the wider world, Jamison re-names it as "sanctuary" which he describes as both "sacred space" and "refuge" (Jamison, 2006, p.22). Regardless of whether one has a faith view or not, Jamison invites the searcher to be open to whatever each may discover as we journey on.

Taking key stages in monastic teaching, Jamison builds this sanctuary "by heart and mind" (Jamison, 2006, p.9). Although deep within one's inner self, it is described as if having the features of a house. I imagine a log cabin.

This thesis, the journey of my research project, is structured using this architectural imagery where both the house and this project describe ways of building a particular space. For the modern Benedictine model, creating space means becoming aware of one's own inner sanctuary and potentially of God's presence there. In my research, creating space is both physical and internal. This means room and time for healthcare professionals to reflect together in their working day. It also means room and time within their team and in themselves for reflection to be a tool for the nurture of their wellbeing.

The Jamison/Benedictine model has been both a personal and professional resource for my internal journeying for a number of years. I have used it for parish study groups, for both parish and pastoral volunteer quiet days, and with clergy colleagues. Using this model, so embedded in my own practice and reflections, the doctoral programme has also been my sanctuary, building the space to reflect with others.

From Jamison's model, I picture the log cabin where the building starts with creating the door. It allows access to the space beyond, to be able to see in or actually step inside. The door is a means of passage from one place to another. It allows admission to further discovery that otherwise, if the door were to be closed, may not reveal what is beyond it. The door is described as virtue, the way in involving work on one's personal life in order to "recognize the sacred in daily life", a doorway to the heart (Jamison, 2006, p. 23). Such a door of virtue examines one's conscience, the way in by a willingness to pause, thinking well of others. It means taking time also to interpret one's own behaviour and involves connection with one's own day to day life (Jamison, 2006, pp.25-27). This links with other traditional models of self-examination, reflection and personal interpretation such as a "review of consciousness" exploring the day's events for personal discovery (Hughes, 1996, p.77).

This was my way in, with the desire to empower others. Stepping inside, the carpet is silence (Jamison, 2006, p.34), taking time to see and focus, to interpret things more clearly, for when the disciple "is quiet…he sees the real state of things" (Jamison, 2006, p.26). It means looking inside and discovering, noticing and interpreting by seeing things as they are now. Thus, I silence myself to listen to the voice of others, in this context the next step being engaging with the literature.

The first chapter of this thesis involves building the walls, the frame of the modern Benedictine sanctuary (Jamison, 2006, p.82). This is the image for the theoretical frameworks placing this research project within practical theology, alongside wellbeing, reflective practice and healthcare chaplaincy. The methodology chapter borrows Jamison's interpretation of St. Benedict's ladder, as the way to the roof of the sanctuary, the process of ascending by falling (Jamison, 2006, p.99). It is the process of growth by the limiting influence, or genuine reality, of self-awareness, symbolizing the steps of self-discovery. This chapter describes the steps or process of this research project journey.

The modern Benedictine sanctuary's windows represent one's community (Jamison, 2006, p.134) shedding light on one's own discovery. In my thesis it is an image for data analysis to take place in the light that is generated by the community within whom the research took place. As windows they help to see, to make discoveries and connections.

The innermost part of the sanctuary is the furniture deep inside (Jamison, 2006, p.138). It is the inner place of self-awareness and discovery, with a willingness to continue to nurture its development. It is the deep place where awareness of God's presence can be known. My fourth chapter reflects on the reflective process used in this project and considers the development of our professional practice.

In the 21st century sanctuary model the last step means the sanctuary is now built, pointing towards its further use and development. In my final chapter I draw conclusions about my contribution to knowledge and practice in reflective practice, healthcare and chaplaincy. I consider how this is being used and could be further developed.

Introduction

"Aching, exhausted, heavy workload…more staff needed" (30th May 2013).

"Huge privilege – want to do my best" (22nd July 2013).

"Nice team who work off the same page" (5th September 2013).

"Feel battered and bruised by the time you leave here" (10th March 2014).

These are voices of healthcare professionals reflecting together within this project. In each case a few from their team, between 3 to 8 people, gathered to reflect together with me, the chaplain, in a room on their ward/unit. For about 20 minutes or so they had both the physical space, and also gave each other space to talk and listen, to reflect within their context. Even these brief examples from the data reveal something of the breadth and depth of their reflections. In this reflective space their conversations reveal the contrast between how much they value their work, and appreciate working with a good supportive team, versus the physical and psychological weight of the job.

The purpose of this thesis is to demonstrate to healthcare and to chaplaincy that building space for healthcare professionals to reflect together, in their team and in their context, is moving towards nurturing their wellbeing. As they have shown, wellbeing to them means acknowledging the holistic, meaning the whole person, multi-layered, more than simply one aspect of their lives. This is in themselves, in their relationship with their team, and in their particular context. This addition to understandings of wellbeing is demonstrated both by my data source and in the wider literature. This project will argue, however, that the healthcare professionals (HCPs) of my research

seem voiceless in the face of poor staff morale. This is also in the face of an institutional understanding of wellbeing in healthcare that focusses on health only and requires the individual to manage it.

My contribution to knowledge and practice challenges the healthcare interpretation of wellbeing and is working towards a reflective praxis that nurtures the wider understanding of it. Doing this within their work culture means this research project has given them room to be both professional and human. Further, by reflecting together on a regular basis engenders a more natural development in the reflective culture. This develops the chaplaincy role reflecting together with HCPs in the same way that they, the HCPs, express their wellbeing meaning in a holistic, relational and contextual way. As this continues to develop and empower HCPs to take this up, the challenge is finding the space or more specifically the need for the space to be acknowledged within the institutional structure. It is both exciting, as HCPs respond so positively, and also challenging as we explore how to continue to build space.

I will now, chapter by chapter, build my argument for reflective space for the wellbeing of HCPs.

Chapter 1 The Walls

Building by listening

This chapter positions this project within its context. It outlines the motives for this research, listening to poor staff morale. It touches on themes of my own relevant reflective background towards using reflective practice for wellbeing. The listening then turns to hear and draw together relevant extant literature within which this project is placed.

The walls of this created space are like the 21st century model of the Benedictine sanctuary walls which are built by listening to others and are key to the structure of the inner sanctuary (Jamison, 2006, p.82). Like any building, they are fundamental to its shape and purpose. They demonstrate its form and identity, its framework, showing what may be visible to others of its design. They not only create the building but support it. The walls inform not only those who see them but contribute to whatever goes on inside. For the modern Benedictine sanctuary, the walls are built by listening more widely with "the freedom of discernment and the freedom of choosing to follow what has been discerned" (Jamison, 2006, pp.76, 77).

In this research project, space for reflection is built in this way, allowing self-development through self-awareness and willingness to hear others. My thesis walls are created by listening to the theoretical frameworks of wellbeing, reflective practice and healthcare chaplaincy. These are set within the contextual and human experience nature of practical theology, to understand and demonstrate where the voice of my own research is placed alongside them.

Listening to poor staff morale as research motivation

In my professional context as a hospital chaplain I seemed to be breaking new ground in using reflective practice as a tool endeavouring to raise the morale of HCPs. I was also developing its practice with pastoral visitor volunteers. My motivations came in early 2010 from two distinct events. At a local chaplaincy conference, I was observed by Dr Harriet Mowat who, seeing me encouraging and making reflection accessible to a group of volunteers, suggested I explore the possibility of my practice as a research project. A few months later, a hospital unit manager asked for my help, saying that staff morale in their team was especially low. Tentatively, I offered to 'do some reflective sessions'. This, I thought, would combine HCPs and clergy as reflective practitioners. This initial experience with staff provided reflective sessions on three occasions lasting no more than half an hour in a meeting room adjacent to their unit, with staff free to attend. On each occasion groups of 5 or 6 staff gathered and instinctively I opened the session by asking the question I often ask in any pastoral encounter: "How're you doing?" This was meant to be as open as possible and has, then and since, often evoked a revealing response, indicating how the other person is, or is not, coping with their current situation. In this case, the staff in these groups said they were particularly grateful for this space to talk and their instant relaxation was palpable.

My desire has been to make a difference to the HCPs amongst whom I work by exploring how reflective practice may help with their stress and low morale. I want to aid their own discovery of the resource of an inner sanctuary. This means making use of and developing both the intuitive-personal and trained-professional reflective space. It is my desire to empower others. This is as a priest alongside them as one who identifies places of change and transformation in oneself and others. I want to help them find

their voice within their own particular story. My professional practice has grown with this research and has changed significantly part of the culture of my own department, within my work and the language we use. Within both institutions of healthcare and the Church I have sensed the potential for developing self-exploration and self-awareness by reflection. This research involves finding a voice for the voiceless, self-empowering and strengthening, and self as a source of discovery and healing.

The professional doctorate programme provided a framework to explore my practice as a chaplain who encourages reflective skills. As I embarked on this, my first objective was to see how HCPs dealt with the challenges of their day to day work. Suspecting that many may find the obligation to use reflective practice for professional development as onerous and frustrating, I wanted to help empower them to make more fulfilling use of this already available skill. To enhance this, I also wanted to find a simple and memorable reflective practice tool readily accessible in the workplace environment that could give space for wellbeing. Like Jamison's modern Benedictine sanctuary, this device is something to carry within oneself, for one's own nurture. It is also intended to help connect with others on their shared journeying.

I will now point to several key influences that have contributed to evolving within me the value of reflective practice as a source of personal inner discoveries. This adds to the motivation for this research.

Listening to my reflective journey towards this research

"All things came into being through Him", says the author of St John's Prologue (John 1.3 NRSV), as he weaves an image of life with change as its very essence. It is life being nurtured from darkness to light, from functional to organic, from nothingness to fulfilment, indeed from humanity to divinity. It is an image of life coming into its fullness through revelation of the

presence of the incarnate divine, woven deep within human experience. To 'come into being' means to grow as a whole person. It is to discover our true selves, how we grow to our fullest potential, into who we *really* are, into whom God has called us to become.

It is this journey of discovery, this vocation to be fully whoever it is that I am, that inspires my yearning to nurture that self-awareness in others. Responding to Lord Dearing's 2001 report, *The Way Ahead,* on the relationship between the Church of England and her schools, Rowan Williams described vocation as "God's summons into existence itself" as each member of the community is called to nurture the development of the whole person (2001, p.92): "Only when I am conscious of being called by God to be myself in Christ can I find what specific work he asks of me in passing on that discovery and that hope to others" (Williams, 2001, p.92). 'To be myself in Christ' means to discover self-awareness through reflection and reflexivity and identify how to fulfil my potential. I am deeply energized by empowering others to self-discover; the nurturing of which is at the very heart of learning through human experience.

An image of the juxtaposition of human experience and the value of reflection is in Ondaatje's *The English Patient* (1992) who travels through continents, cultures and years, unfolding the anguished story of a severely burnt and disfigured pilot. His experience of love and loss takes him across the wind, sand-stormed, mountainous desert of his cartographic work in 1930s Egypt. It also takes him deep within his inner wilderness, re-told through his journal as he allows his nurse to be alongside him, re-living every moment. In the quiet of his room, and as he lies in his bed, he re-traces his steps. His narrative reveals, both to himself and the nurse, his experiences and inner voice. This is the image of the patient telling his own story and through it discover and explore, in the depth of his own spirit, a place of

further discovery, inner wellbeing, strength and peace: "He whispers again, dragging the listening heart of the young nurse beside him to wherever his mind was, into that well of memory he kept plunging into during those months before he died" (Ondaatje, 1992, p.4).

So, with the well as an image of inner depths and the place for recognition and learning, it is also a place of meeting. It was at a meeting around the well, where the promiscuous Samaritan woman had come to collect her water, that the Gospel writer (John 4.7-14 NRSV) described her encounter with Christ. Through dialogue with Him and personal discovery, she was promised a deeper life of lasting fulfilment. The well then is a place of gathering, a sacred place where all are welcome, encouraged to tell their story, and are heard (Stancliffe, 2003, p.48). It is also an inner personal place of discovery, or a "liminal space" where "creative soul-work happens" (Whorton, 2011, p.36).

Another image of the meeting place is the disciples and Jesus on the Emmaus Road as He joins them and asks, "What are you discussing with each other as you walk along?" (Luke 24.17 NRSV). It is a model of the pastoral encounter. Jesus comes alongside them but makes no demands, save for inviting them into conversation. It is a dialogue, being alongside one another, being together, and yet it is also space. It is a place for transformation (Stancliffe, 2003, p.67). Jesus, in this context, is a companion on the way. The scene is a model for encounter, self-awareness and personal development. The disciples looked back and saw how the whole journey and encounter had transformed them, and now had the energy to continue on and towards new discoveries. These meeting places provide space for inner discovery where reflection, or inner digging, is a source of learning. From the parable image of "the kingdom of heaven is like treasure hidden in a field" (Matthew 13.44 NRSV), the Jesuit priest Gerard Hughes urges digging for treasure in the most unlikely place – within oneself (Hughes, 1996, p.xiv).

This kind of inner personal journeying, as seen in monastic life, has been made available within normal busy daily living. As has been described, the 21st century Benedictine sanctuary, shown in the TV series *The Monastery* and book *Finding Sanctuary* (Jamison, 2006), offered steps toward inner discovery and an alternative more lasting route to inner peace. It is this journeying nature of personal development, the sanctuary building, which has also helped develop, within me, this sense of building space.

These examples of inner listening, drawing together human experience and personal reflection as a form of journeying and space for discovery, contribute to my position on the value of reflective practice. Part of my own story is listening to such examples of the interweaving of human experience and personal discoveries. This is my context but its significance for my research is the desire to empower others to find, through reflection, their own voice, their story and revelations.

I now move to listen further to others, to consider the literature alongside which I place my research project.

Listening to the literature

Listening to others, I draw together voices of wellbeing, reflective practice and healthcare chaplaincy. I want to show how my contribution to knowledge and practice challenges the healthcare definition of wellbeing and is working towards a reflective praxis that nurtures a more holistic understanding of it. I will also show that this project develops the literature on wellbeing in the healthcare context. With healthcare chaplaincy as a paradigm of practical theology, this project develops the pastoral nature of the encounter between chaplain and HCPs. It also moves towards HCPs care of themselves and each other both in their professional lives and their own humanity.

Listening to human experience

This research project is a human story that starts and ends with human experience. It is a ministry of the practice of conversations and reflection about human experience, of listening and learning through reflection towards a sense of wellbeing.

Practical theology is "always contextual" (Graham, Walton, and Ward, 2005, p. 10), "studying lived experience" while "holding the immediacy of praxis and narrative in creative tension" (Graham, 2012, p.198). Within this understanding of practical theology, my research project is a study of my practice of reflection as chaplain with HCPs. It is a place for learning "in ministry or action" within "the human context and the realities of lived experience" (Graham, 2017, p.173). This will be developed further in Chapter 4 where building or creating the reflective space within the pastoral encounter with HCPs is discussed.

In support of my project I take illustrations from Richard Osmer, Elaine Graham and Eric Stoddart whose individual work shows human experience as

a tool for transformation by engaging with the human story for each in the pastoral encounter. In this research project the pastoral encounter is with the chaplain, as a listening reflective companion, and HCPs engaged in their human story that is told and heard within this reflective space. This project builds space in order to find discovery through human experience.

Developing discovery through human experience (Osmer, Graham, Stoddart)

My research connects with Rick Osmer's model (2008) of learning through the realities and complexities of the pastoral encounter. He uses vivid human stories, reflection on real pastoral encounters, as tools for learning. He promotes a method of clergy development so that they may be better pastoral care providers. He advocates his "core tasks" of being alongside others with "careful listening" (Osmer, 2008, p.73), interpreting through "thoughtfulness" and "wise judgement" (Osmer, 2008, pp.82-85), and through "cross-disciplinary dialogue" (Osmer, 2008, p.172). The final 'task' is leading by the visibility of one's own humanity and vulnerability towards "an ability to empower others" (Osmer, 2008, p.192). This holds together human experience and reflection, while being alongside others in the process of growth and change. This is a key element in my project working as chaplain with HCPs.

Osmer's own journey is through Gerkin's hermeneutical relation between pastor and people with priest as "interpretive guide" (Osmer, 2008, p.33). He develops the connectedness of Miller-McLemore's "living human web" onto his wider term "web of life" (Osmer, 2008, p.33). This means being alert to the reality and complexities surrounding the layers of the pastoral encounter. He asks clergy to respond to this "challenge of double reflexivity" (Osmer, 2008, p.240) meaning seeing the change in oneself and in one's community. Developing this in the healthcare context, I explore the priest/chaplain who

through the pastoral encounter of the reflective space with HCPs moves towards a form of reflective practice that fosters a new sense of wellbeing. This is a 'double reflexivity' for HCPs and the chaplain. The HCPs empowered to create space, share and reflect on human stories, find change in themselves and in their work community. By both professions developing their own practice they are sources of mutual learning in their reflective pastoral encounter.

This relates to Elaine Graham's further development of the "living human document" which she takes beyond the clergy study model, describing it "as an entry-point into a deeper apprehension of the very meaning of human existence" (Graham, 2009, p.151). Further, it is "any instance of pastoral practice or encounter, regardless of its actual agent or locus" (Graham, 2009, p.151), therefore a source of learning within and beyond the Church. Valued in whatever way they are presented, "those 'texts' are always embodied, gendered and contextual" (Graham, 2009, p.151). This is discovery through human experience, in whatever way it may be identified and interpreted. My project moves towards helping HCPs see themselves in this way as their own learning resource.

Returning the 'living human document' to its origins in chaplaincy and healthcare re-associates with Anton Boisen's intentions. The 20th century chaplain and educator saw this 'document' as a personal and professional source of learning. Using his own story, finding the medical treatment of his mental ill health "cold, clinical and lacking in meaning" he felt "called to consider who he had become" with so much more to be gained by "deep self-scrutiny" (O'Laughlin, 2005, pp. 48, 49). Exploring his life and studies, the people around him, his own self-awareness, and in his own reflections found that "understanding his own life, in all its detailed singularity, had been the key to his recovery" (O'Laughlin, 2005, p.49). Developing the value of the

individual story, both personal and in case study, he saw the 'living human document' as an essential learning resource (O'Laughlin, 2005, pp.49, 50).

This project empowers HCPs to recognize the human story as a source of learning and this discovery as a shared experience. Regardless of faith or institution, people sharing this together are on "pilgrimage: journeying, on the move, telling and sharing stories and occasionally visiting sacred places" (Graham, 2009, p.152). Graham develops this as "inclusive and non-sectarian" but nevertheless "with all those who identify themselves as the people of God" (Graham, 2009, p.152). However, I think this is possible for those journeying together where not everyone would identify themselves as people of faith. The shared experience of chaplain as the reflective companion in the pastoral encounter with HCPs could be described, as has been said of God's Kingdom, "living at the threshold between sacred and secular" (Graham, 2011, p.233). Further, at such an interface any contribution from the faith perspective "must be offered in the name of a common humanity and shared concern for its flourishing" (Graham, 2011, p.233). If at that interface then, the chaplain is the practitioner engaged in that 'shared concern'.

From his own story, Eric Stoddart (2014) shares insights into his transformation and flourishing, and its effect on his evangelical background (Stoddart, 2014, p.12). He describes learning "the power of reflective listening", moving his understanding in the pastoral encounter from giving advice to the "hospitality of listening" and "creating space for another" (Stoddart, 2014, p.5). For him it was "a shift from listening for God to being silent for God", seeing his own ecclesiology and theology move to "creating space wherein a person could come to insight" (Stoddart, 2014, p.6). Stoddart is the listener in the pastoral encounter who is deeply changed by the experience. He moves in his understanding and experience of the pastoral encounter and pastoral care. This mirrors Osmer's "challenge of double

reflexivity" (Osmer, 2008, p.240) for both in the pastoral encounter, as well as Graham's "embodied, gendered and contextual" nature of 'living human documents' (Graham, 2009, p.151). It links also with the "mutual hospitality" of the pastoral encounter (Walton M., 2012, p.226) which is highlighted later in this chapter and in Chapter 4 further developed.

Sharing his discovery though his own human experience, Stoddart develops practical theology arguing it must include the "voice, needs and contribution of those who are marginalized" (Stoddart, 2014, p.144). This connects with my research project with HCPs use of reflective practice to share their story in the face of their professional challenges and as a means of moving towards their own wellbeing. In this project the pastoral encounter of their reflective space is the place for listening, reflection, self-discovery, finding a voice for the voiceless. As the data will reveal, the HCPs appear to be unheard so this is an opportunity to speak together in the face of their low morale. This is also within an institutional understanding of wellbeing that does not focus on the whole person, nor in relation to one another or their context.

Thus far I have demonstrated the motivation for my research project and placed my work alongside the human experience and pastoral encounter motifs of practical theology. I shall now argue, challenging the healthcare understanding of wellbeing as part of the motivation for the project, for a new understanding of wellbeing.

Wellbeing is also holistic, relational and contextual

The NHS and the health model (Boorman, 2009 and NHS papers, 2011)

Being invited to help boost staff morale prompted, in due course, my investigation of provision at the time for wellbeing in healthcare staff.

With high absenteeism due to sickness levels among healthcare staff The Department of Health invited Dr Steven Boorman to examine health and wellbeing among these employees (Boorman, 2009). Some 11,500 NHS staff in the UK took part in a staff survey and a 1000 of them in several consultation events (Boorman, 2009, p.3). The resulting report identified that "staff health and well-being is more than just the absence of disease [but rather] an emphasis on achieving physical, mental and social contentment" (Boorman, 2009, p.2). It noted "concerns about reported levels of stress" with the need for "improving attendance" in order to continue "maintaining high standards of care" (Boorman, 2009, p.2).

The Boorman Review's key recommendations promised to be a resource to reduce sickness levels. It identified the need for staff to "have productive and rewarding jobs...to reduce sickness absence and increase productivity by increasing staff availability. Improving the health and wellbeing of staff is key to enabling the NHS genuinely to provide health and well-being services for all" (Boorman, 2009, p.29). This would be based on managing issues of "both work-related and lifestyle-influenced ill-health" in terms of prevention with especial responsibility for managers "to recognise the link between staff health and well-being" (Boorman, 2009, p.30) This would also include close monitoring of staff sickness records, "return-to-work interviews and completing staff appraisals" (Boorman, 2009, p.34) and for the hospital's

occupational health department to become instead the "'NHS Staff Health and Well-being'" (Boorman, 2009, p.32).

The whole NHS Health and Wellbeing Report (Boorman, 2009) seems to provide the model for the ideal employee to whom support is to be given for "early and effective interventions for common musculoskeletal and mental health problems" (Boorman, 2009, p.31). It includes reducing smoking and alcohol, having better food and eating advice, reducing obesity, and monitoring staff. It calls for "all NHS bodies [to] ensure that their management practices are in line with the Health and Safety Executive's management standards for the control of work-related stress" (Boorman, 2009, p.32). So, the Boorman Review creates the model for a fit and stress-free employee.

Exploring other NHS documents, issues of "mental wellbeing" and concerns over "work related stress" are acknowledged (National Institute for Health and Care Excellence, 2009, p.6). Nevertheless, the emphasis seems to be on management structure, or strategy recommended related to communication, staff surveys, working hours and use of occupational health. The later Department of Health (DOH) report, *NHS Healthy Staff, Better Care* (DOH, 2011), focuses on the place of the occupational health in the hospital environment that fulfil the 6 core areas of "prevention, timely intervention, rehabilitation, health assessments for work, promotion of health and well-being and teaching and training" (DOH, 2011, p.5). It also aims to develop occupational health work as a medical specialism today. These NHS health and wellbeing papers seem to focus on the reorganization of occupational health with apparently little evidence of exploration into wellbeing beyond the physical health model as outlined above in Boorman (2009, pp.31,32). This criticism may seem rather ironic, but I want to know what further help is offered holistically. Holistic is defined as 'whole person' (from Greek 'holos'

meaning 'whole') so the physical, psychological, social and spiritual aspects of a person, where no one aspect can be taken in isolation (McSherry, 2006, p.74). My further evaluation of these reports is that they appear not to include resources for wellbeing aid at staff/patient or colleague level in the work context. This means the healthcare workforce is likely to experience stress.

Not content that these NHS papers, available at the start of my research project, gave sufficient attention to the holistic wellbeing of healthcare staff, I investigated a broader understanding of wellbeing. Challenging the institutional emphasis which focuses largely on physical health, fitness for work and an individual's responsibility to achieve this, I wanted to see if this is really sufficient. I also considered whether the chaplain's work of caring for the whole person in pastoral and spiritual care could include reflecting with a variety of HCPs. I wanted to know whether their reflections would mirror a wider, more holistic sense of wellbeing. Further, would they value this inclusion of deeper reaching resources for exploring personal and professional day to day issues in their own team and context?

What *is* 'wellbeing'?

Anthropology

> *Well-being as an organic multi-layered experience, "an optimal state", for individuals and communities (Mathews and Izquierdo, 2009, p.5*)

The word 'well-being' implies wellness within one's being. Dictionary definitions include "the state of being comfortable, healthy or happy" (Oxford Dictionaries, 2012) and "the condition of being contented, healthy, or successful" (Collins Dictionaries, 2012). These indicate that, while wellbeing may include health, there are deeper and broader elements.

In their work examining wellbeing across societies and cultures, two anthropologists say that these elements in the dictionary definitions of wellbeing "indicates that wellbeing might refer to any of these...attributes, but...implies their interconnection" although "not necessarily related". They instead prefer wellbeing as the "broader panhuman term" (Mathews and Izquierdo, 2009, p.3):

> Wellbeing is an optimal state for an individual, community, society and the world as a whole…conceived of, expressed, and experienced in different ways by different individuals and within the cultural contexts of different societies [but] bears a degree of commonality due to our common humanity and interrelatedness…is experienced by individuals...interpersonally and inter-culturally, since all individuals live within particular worlds of others, and all societies live in a common world at large (Mathews and Izquierdo, 2009, p.5).

While wellbeing is a subjective experience, it can be more deeply understood and developed when each person becomes aware of the experience of others. Wellbeing, then, is neither merely a functional activity, nor is simply related to health. It is an organic multi-layered experience and connected with the culture or environment in which anyone lives and works. Miles-Watson (2011) links ethnography and wellbeing to discover "an understanding of happiness that is grounded in lived experience". Such a research method "provides examples of ways of engaging with the world that reflect back on our lives, resulting in the realization that wellbeing everywhere is contingent upon interpersonal relations" (Miles-Watson, 2011, pp.125, 133).

From this initial exploration it is evident that wellbeing is more than health and embraces the whole person, the many layers that make up life and one's connection with others. Wellbeing can be found through one's "web of life"

(Osmer, 2008, p.33). Taking this further from considering human life in society, I now consider the wellbeing perspective in studies of society.

Sociology

Wellbeing connects feelings, life fulfilment and the way of self-assessing life issues (*Deiner and Biswas-Deiner, 2008, cited in Atherton, 2011, p.7).*

Wellbeing also connects with the culture or context in which anyone lives and works (Miles-Watson, 2011, p.133).

Wellbeing then involves connections with oneself and with one another in context. Not simply a physical occurrence, it also threads through every layer of human experience. Ed Deiner, psychologist and wellbeing researcher, places happiness as "subjective wellbeing" which "involves frequent pleasant emotion, infrequent unpleasant emotion, and life satisfaction" but also includes other factors like "meaning and purpose in life" (Tov and Deiner, 2009, p.10). Elsewhere he adds (as cited in Atherton, 2011) "emotional wellbeing – how we feel; cognitive life satisfaction – how we judge we are doing in life; and psychological flourishing – to what extent we positively evaluate major domains or aspects of life, including health, work, relationships, leisure, religion or spirituality" (Atherton, 2011, p.7).

Rath and Harter (2010) identify five features of 'career, social, financial, physical and community' which they call "the universal elements of wellbeing that differentiate a thriving life from one spent suffering" (p.5). They argue that the way these connect provides the means to "a more holistic view of what contributes to your wellbeing over a lifetime" (Rath and Harter, 2010, p.10). Their recommendations include developing one's career by finding the support of a colleague, "someone with a shared mission" and spending "time with people and teams you enjoy being around at work" (Rath and Harter, 2010, p.29). So, wellbeing can be increased by talking with colleagues,

looking for their support and shared understanding, getting to know one another in one's working team. This project explores the potental for colleagues to support one another in this way.

If team can mean professional colleagues, and if wellbeing is linked with one's culture or the connections with people around us, then this adds to the view that wellbeing can be shared. Deiner (2009) explores the connection between wellbeing and cultural influence and concludes: "The values of people in a particular culture, as well as the nature of their everyday experience, influence the factors that most strongly affect their wellbeing" (Deiner, 2009, p.5). While there are some universals there are "also influences that seem specific to different cultures" (Deiner, 2009, p.279). For example, exploring the variety of inhabitants of Calcutta he suggests this explains their sense of wellbeing beyond "the deficits of poverty and poor health but includes the positive aspects of...[their] lives" such as relationships, family, and community (Biswas-Deiner and Deiner, 2009, p. 275). Deiner concludes that "while the poor of Calcutta do not lead enviable lives, they do lead meaningful lives" (Biswas-Deiner and Deiner, 2009, p.276). Wellbeing then is particular, as well as generic, but also goes beyond assumption. Exploring the comparison of wellbeing in different places and for different people Mathews and Izquierdo (2009) conclude that the benefit is to consider wellbeing "ethnographically and cross-culturally" (p.13). This supports the possibility of working towards developing wellbeing through healthcare staff and chaplain working together, akin to the transformation through "cross-disciplinary dialogue" (Osmer, 2008, p.172) in the pastoral encounter.

Deiner (2009) deduces that "'culture' is...a more flexible concept that can vary at different levels of inclusiveness" and that while there are "human universals and cultural particulars", anyone's wellbeing is also affirmed when one has "a deep feeling that one is living correctly" (Deiner, 2009, pp.284, 285). Exploring

connections between wellbeing, religion and economy Atherton (2011) identifies that the understanding of wellbeing is broadened by seeing, as in Deiner's work, "objective economic and social indicators of wellbeing" and "social as well as personal wellbeing...[the] ethical as well as religious dimension. Wellbeing is therefore also associated with an ability to connect to values external to oneself" (Atherton, 2011, pp.7,8). Once more then, wellbeing is both personal and cultural, has a "multidisciplinary nature" and with "mutual benefit" to each (Atherton, 2011, pp.17,18).

The NHS, by its very nature, is a microcosm of society experiencing the variety of acute human challenges, as well as cross-cultural. People work in the community of their own team and context as their primary focus. However, they also work as part of the wider institution, in the multi-disciplinary team of other professional and non-professional colleagues. They share the same humanity, real people with personal circumstances at home as well as at work. Their environment is multi-layered, being both personal and contextual, as well as being part of the wider culture.

Moving on from considering wellbeing studies in anthropology and society, I will highlight the national interest and then, giving further evidence of wellbeing as relational, return to challenging the NHS interpretation.

National statistics and enquiry 2011 - 2015

"Measuring what matters…" (ONS, 2015)

If wellbeing connects with one's life experience, one's feelings, relationships, context and culture (Deiner, 2009; Miles-Watson, 2011) then it is of universal concern:

> Personal well-being, people's thoughts and feelings about their quality of life, is an important aspect of national well-being. It is part of a

much wider initiative in the UK and internationally to look beyond GDP to measure what really matters to people (ONS, 2014).

Now both a national and international topic of interest and research, it is an additional means of evaluating a country's development, and of informing government policy (ONS, 2015). The Office for National Statistics (ONS) began generating this data in 2011/2012 and have used "four measures of personal well-being", namely "life satisfaction", "feeling what one does in life is worthwhile", "happiness yesterday" and "anxiety yesterday" (ONS, 2014). Their research tool is an annual population survey, claiming it to be "a very cost effective means of measuring personal well-being" (ONS, 2014, p.31). The analysis for 2015 suggests that annually, with varying levels in different geographical areas, personal wellbeing has grown (ONS, 2015).

From the national statistics, wellbeing clearly has a far broader contribution to people's lives than simply physical health. A healthy life is naturally profoundly desirable, yet wellbeing brings a greater richness to it. It connects with one's whole life, as well as one's local and wider society. In the NHS the focus is on the individual's responsibility to fulfil the wellbeing expectations of their employer and for which products or programmes are available to follow. I challenge this, drawing attention to a wider view of wellbeing that also relates to the whole person, to people in relation to others and in their context.

Wellbeing for people, not a product

"…work being done to create a happier and more caring society…" Dalai Lama comments on new 8-week course by the Action for Happiness organization September 2015 (Easton, 2015)

Since the start of this research project in 2010, and the generation of data 2013-14, there has been a growth in wellbeing material nationally and

internationally, as has been indicated. In the wider arena the understanding of wellbeing seems to link with the more organic whole person, their feelings, relationships and community. Institutions, employers, charities, student groups, almost every organization has wellbeing in its portfolio.

The charity MIND offers five areas for individuals to explore for their own wellbeing. These include physical activity, further learning, noticing the world around oneself and giving to others, but with "making connections" at the top of their list. This is on the basis that "feeling close to, and valued by, other people is a fundamental human need and one that contributes to functioning well in the world" (MIND, 2017). This fundamentally links with the relational aspects of other identified understandings of wellbeing.

As an example of larger institutions involved in the breadth of 21st century growth of work and study in human wellbeing, The University of Cambridge's Well-Being Institute describe their work in "the study of human flourishing". They say it encompasses the five areas of "individual, family, organisation, community, society" as a forum for research, training, professional development, connecting with society and policy making (Well-Being Institute, 2015). Their work aims "to make major contributions to the development of new knowledge and its application in enhancing the lives of individuals and of the institutions and communities in which they live and work" (Well-being Institute, 2015).

Yet for the NHS management, the emphasis remains on providing a product rather than developing the whole person in their immediate work context. In September 2015 the NHS England Chief Executive Simon Stevens announced a "major drive to improve the health and wellbeing", citing the 2009 Boorman Report. This would have three "pillars" involving NHS staff, care of GPs suffering from stress and food standards for staff also. For hospital staff the

focus was on physical health and fitness support, as well as healthy food options for staff on the hospital site (NHS England, 2015).

This announcement also encouraged hospitals to sign up to The Workplace Wellbeing Charter (Public Health England, 2016) which is "for employers to demonstrate their commitment to the health and wellbeing of their workforce" with the aim of planning and standard setting. The eight main headings are leadership, absence management, health and safety, mental health, smoking and tobacco, physical activity, healthy eating, alcohol and substance misuse. The 'mental health' section includes commitment to "provide information…to reduce the stigma around mental ill health", "about mental health and wellbeing including work-related stress" with "mental health awareness training", "staff surveys", "confidential support service" and means of support by "intervention programmes eg retirement, redundancy planning". Perhaps one section hints at the *person* at work: "Social support groups, volunteering and out-of-work activities are actively encouraged and supported by the organisation" (Public Health England, 2016). These areas of 'health and wellbeing' continue to be related to the physical in terms of both health and employee presence. They also continue to emphasise the onus on the individual rather than the institution.

A further 'tool' for wellbeing has been described in the growth of the use of resilience. As a lead in NHS professional development, Chris Lake describes resilience as key in NHS leadership. As a response to staff surveys, managers consider how to respond to low morale, staff sickness and high levels of stress. He says that it is regrettable that resilience is needed, and that the organisation would be better "dealing with the source of the pressure rather than teaching our staff strategies to survive it" (Lake, 2016). Nevertheless, he affirms: "Resilience is the quality that allows people to flex and adapt to the inevitable winds of life, to be knocked down and to come back rather than

letting lumps and bumps overcome them and drain their resolve" (Lake, 2016).

Personal resilience has been defined as the "ability to succeed, to live, and to develop in a positive way…despite the stress or adversity that would normally involve the real possibility of a negative outcome" (NHS England, 2015). As such it feels more like a technique, even a product, a means of fighting back, rather than resourcing the inner lives of healthcare staff. Classes and resources also require attendance away from the work space.

While there is a concern with staff morale and absenteeism in the NHS, as an institution it narrowly focusses on its health interpretation of wellbeing, and yet it remains the individual's responsibility to address it. However, my project moves towards empowering HCPs, as people, to nurture a deeper sense of wellbeing *within themselves and among their team* in their own work context. Challenging the healthcare understanding of wellbeing I have shown a wider awareness of it through anthropology, sociology, national statistics, and with examples of its breadth of coverage. Returning to recent public health documents the healthcare understanding of wellbeing remains ironically dominated by physical health and absenteeism, and individual focussed.

I have shown that wellbeing however is *also* holistic, relational, and contextual. Holistic means relating to the whole person, the different aspects of one's life. Relational means people in relation to others, one's community, one's team. Contextual means one's situation or circumstances, their context, at this time. This developed understanding of wellbeing has come from the literature.

My research project is placed in the context of the working lives of HCPs in a particular hospital setting. I will show, from the generated data, the issues of

wellbeing that HCPs raise in their reflections. As will be seen, these include the human connection between themselves and with their patients, valuing the space to reflect together, the desire for shared team support and a shared goal. They look too for a sense of job satisfaction, making a worthwhile contribution, in this demanding culture. These together I argue are consistent with the broader definitions of wellbeing. Combining the wellbeing found in the data themes and tested against a wellbeing definition tool, further data analysis also reveals a wider definition *in addition* to that of only health. This I will further argue invites national attention to a national concern.

Seeing that wellbeing also involves the whole person in relation to their community and context, I want to explore reflective practice as a tool to nurture this.

Reflective Practice - 'living human documents' nurturing wellbeing

The thread of this project tests my ontological and epistemological position which involves my experience and view of the personal and professional value of reflective practice. (My position will be explored in my methodology in Chapter 2.)

Being a "reflective practitioner" as a means of progression beyond being a competent professional (Schön, 1983), has underpinned education and professional development. This is most notably in teaching, nursing and other social care professions (Moon, 1999; Johns, 2009; Bolton, 2010). This includes the essential place of theological reflection in theological study, clergy training and ministry (which will be explored later in this section).

Reflective practice as part of clinical supervision in nursing has been a policy and expectation from professional authorities since 1993 (Powell, 2002, p.16; Cerinus, 2005, p.34). However, there were concerns that this tool would be seen as an imposition from the educators rather than a valued skill to be used day to day (Williams and Lowes, 2001, p.1482). It was feared that the management structure of a ward unit would prohibit practitioner reflection (Mantzoukas and Jasper, 2004, p.932). Despite the wealth of material urging HCPs to embrace and nurture it, they vary widely in their use of reflective practice, as both the pilot study and research data of this project will reveal. This research project, however, points towards the value of reflective practice for deepening self-awareness and personal growth for HCPs.

From my own experience of reflective practice as an internal self-help resource, my research facilitates reflection with HCPs who, from their training, have some knowledge of reflective practice. I use the reflective companion skills of the chaplain to facilitate reflection in their working environment and nurture its use. They explore the potential value of reflecting for wellbeing, reflecting together, and to self-support this in their teams. This encourages HCPs to see themselves as valuable sources, 'living human documents', of learning for wellbeing.

This project combines the essential root of practical theology, meaning the chaplain's practice of theological reflection, with the professional development reflective skills of the HCPs. This connection moves reflective practice in healthcare from a tool for professional practice to a natural resource for personal wellbeing, explored through HCPs own story.

Parables and seeing the deeper story - learning from experience

The "highway of life" is a "storied existence" where stories explain and validate our human experiences (Bochner and Riggs, 2014, p.196). Indeed, the

"hospital is a place of stories" (Swinton, 2015, p.300). The environment where the most acute events of human experience are encountered is then a rich forum for stories and learning.

The stories, or parables, made familiar through public Gospel reading, intended to be memorable, form much of the material of Jesus' teaching. They follow a theme or image, relevant to the people at the time of the telling, to link God's story with the human story. As the Gospel writer explained, what people see and hear they fail to perceive or understand (Matthew 13.13 NRSV), so by rehearsing the familiar story the deeper learning becomes clear. From the Greek 'parabello' (meaning 'alongside') and 'paraballein' (meaning 'to throw beside'), the parables allow the known to make clearer the unknown (Brown, 1986, p.747). This brings human experience alongside the metaphor, inviting the listener, or reader, into the story, beyond the words into a fuller or deeper insight. In all of human life, as well as in the hospital, the real life situation is a vehicle for learning. From childhood to daily living, the human story has taught that learning from experience is an essential life-long tool. Reflective practice is simply learning from experience, where the story is told and explored, and the learning discerned.

Learning from experience and professional development

Reflective practice as a means of learning from experience thus has a long history. From 5th century BCE Greek philosophy, the Socratic dialogue explores learning virtue by recollection or, like the parables, learning through what is already known (Plato, 1956, p.130).

John Dewey's early 20th century work, in education, thinking and reflection, is complex yet foundational. Writing two versions of his work *How We Think* (1910/1933), he explores types of thought, namely belief, imagination, stream

of consciousness and reflection. He defines "reflective thought" as "active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it, and the further conclusions to which it tends" (Dewey, 1933, p.9). This means being engaged with an experience, the "grounds", the circumstance, being consciously aware of that moment and being willing to engage with it. Using the image of walking along, deducing weather changes, he sees the difference between fact and what something may signify: "The seen thing is regarded as in some way *the ground or basis of belief* in the suggested thing; it possesses the quality of evidence" (Dewey, 1933, p.10). The "seen thing" prompts wider deeper thought and discovery. Initially Dewey sees "reflective thinking" having 2 "phases" - firstly "a state of doubt, hesitation, perplexity" and, as thinking begins, secondly "an act of searching, hunting, inquiring", in order to "resolve" the "uncertainty" (Dewey, 1933, p.12). A "perplexed wayfarer" finds "a forked-road situation" and "looks for evidence" to direct the way forward - so "reflection is aimed at the discovery" (Dewey, 1933, p.14). It is a process of exploring the experience to find a solution. This process "consists of a succession of things thought of" but "not simply a sequence of ideas, but a *con*-sequence – a consecutive ordering" (Dewey, 1933, p.4). Here "successive portions of the reflective thought grow out of one another and support one another", so "reflective thought is a chain" and "aims at a conclusion" (Dewey, 1933, pp.4,5).

He develops this into "five phases, or aspects, of reflective thought" in looking for solutions to problems (Dewey, 1933, p.107). These "states of thinking" are firstly, "suggestions" or "an idea of what to do" then secondly, "intellectualization" or turning what "has been felt (directly experienced) into a problem", meaning identifying it (Dewey, 1933, p.107). The third phase is the "hypothesis", exploring the early suggestions to see "what we do with it, how we use it" (Dewey, 1933, p.109). Fourthly, he proposes "reasoning" which

"helps extend knowledge" and finally he advocates "testing the hypothesis by action" (Dewey, 1933, pp.111, 112, 113). Although saying this process has "a consecutive ordering" (Dewey, 1933, p.4) he says the 5 phases "do not follow one another in a set order" (Dewey, 1933, p.115). Each part contributes to the whole, with each potentially bringing "new observations" and any phase "may telescope, some of them may be passed over hurriedly" or one phase bring the solution (Dewey, 1933, pp.115, 116). Dewey points out: "One can think reflectively only when one is willing to endure suspense and then undergo the trouble of searching" (Dewey, 1933, p.16).

Later in *Education and Experience* (1938), Dewey identifies that the desire or need to reflect comes from engaging with an experience. He affirms the importance of education that connects with the "living present" and "personal experience" or "actual life-experience" (Dewey, 1938, pp.23, 25, 89). An experience is an engagement between the person and the world around them. "The environment is…whatever conditions interact with personal needs, desires, purposes, and capacities to create the experience which is had" (Dewey, 1938, p.44). So, the experience is an "interaction" between both the self and the surroundings (Dewey, 1938, p.42), and both are changed. "They intercept and unite" (Dewey, 1938, p.44). A person then carries learning from the previous situation into the next, so the learning from before "becomes an instrument of understanding and dealing effectively with the situations that follow" (Dewey, 1938, p.44). Both "continuity and interaction" remain linked and this "goes on as long as life and learning continue" (Dewey, 1938, p.44).

Inspired by Dewey, Donald Schön's work on reflective practice developed out of "a kind of knowing-in-practice", or "knowing-in-action" (Schön, 1983, p.viii) to become a tool for study and professional development. He used the phrase "reflection-in-action" meaning to learn from the immediate experience (Schön, 1983, p.54). Here the practitioner "re-frames" or sees from

another perspective (Schön, 1983, p.131). They are then able to develop towards a solution, in the light of previous experience yet still "unique" to the current situation (Schön, 1983, p.137).

Donald Schön took to task the limitations of being a technically competent professional and 'their' capacity to continue without any sense of development (Schön, 1983, p.12). He recognized the growth in the latter 20th century of tension between being professional versus the growing evidence of those elsewhere with identifiable and developing skills. So, he argued for "an epistemology of practice implicit in the artistic, intuitive processes...to situations of uncertainty, instability, uniqueness" (Schön, 1983, p.49). His phrase "reflective practitioner", the title of his work, is born. Using reflection for development, his work means that "professionals must now demonstrate an ability to respond with flexibility to situations of change and flux...proactive learners and risk-takers" (Graham et al, 2005, p.4). Alert to their present situation, and its complexities, the professional develops with the significant tool of "reflection-in-action" and "becomes a researcher in the practice context" (Schön, 1983, p.68). He described this as "a reflective conversation with the situation" (Schön, 1983, p.163). Interestingly, he made only a brief suggestion of the "reflection-on-action" describing the risk of becoming permanently reflective, so potentially prohibiting action! (Schön, 1983, p.277). Yet, this has become a more familiar way of describing the pause to reflect, a period of reflective practice taking place some time subsequent to an event or experience.

With the wealth of development in reflective practice since Schön's work, it is the 'reflective practitioner' that has formed the basis of much of reflective practice in healthcare professional development (Moon, 1999, p.57). From this, my project researches with HCPs' existing awareness of reflective

practice to move towards empowering them to use it for their wellbeing. It is however the spontaneous, in-the-moment, reflecting in the work context that will be argued as part of the contribution of this project to the reflective culture in healthcare.

Having highlighted the storied nature of human life as a source for learning from experience, and the origins of reflective practice as the tool for this, I want to explore relevant examples including in healthcare and chaplaincy. This will support my argument for moving towards developing a reflective praxis for wellbeing for HCPs to use in their context.

Learning from examples of reflective cycles

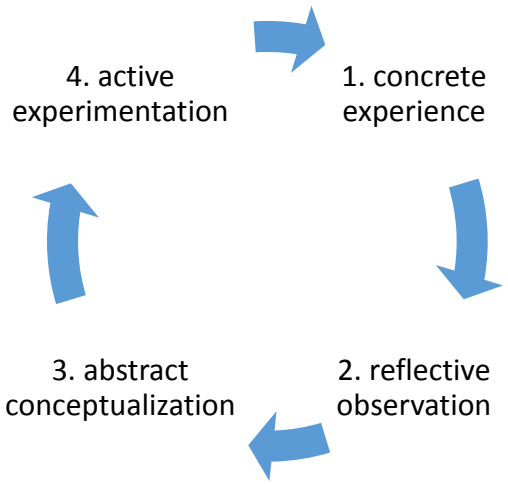
Kolb (1984) – a 4 stage cycle

Drawing from theorists of experiential learning, including Dewey, David Kolb develops this for use in human contextual practice. He combines processes developed from education, the engineering laboratory and psychology, that merge "experience, perception, cognition and behaviour" (Kolb, 1984, p.21). These he summarizes as a learning process based on experience and adaption (Kolb, 1984, pp.26-31) and as a continuing contextual tool:

> When learning is conceived as a holistic adaptive process, it provides conceptual bridges across life situations such as school and work, portraying learning as a continuous, lifelong process (Kolb, 1984, p.33).

For Kolb this means the fluidity of learning rather than solution finding, where learning is "the process whereby knowledge is created through the transformation of experience" (Kolb, 1984, p.41). He develops his version of the learning cycle as phases of "grasping" (stages 1 and 3) and "transformation" (stages 2 and 4) (Kolb, 1984, p.41). This is, in turn, learning through the experience then noticing through reflection, followed by deeper

thinking to make sense of the situation, seeking answers, and the subsequent action.



Kolb, 1984, p.42

From Kolb's major work in "experience as the source of learning and development" (Kolb, 1984), he goes on to draw together theories of learning and learning styles through education, work and career. He includes the process of development through the 4 stages of the learning cycle, depicting it as a cone where the base is initial learning, which in each of the cycle stages can move at differing paces, joining at the summit with "self as process – transacting with the world" (Kolb, 1984, pp.140, 141). This is evidenced in my pilot study with the way in which people differed in their limited recollection and hitherto response to the reflective process.

Seeing experiential learning as a lifelong tool, Kolb argues that "integrative development" is an important "challenge" yet fulfilling element of such a learning process (Kolb, 1984, p.209). This means being able to combine and sustain personal development in one's own work *and* use integrity as a wider, deeper and truthful sense of self knowledge. The purpose of the latter, argues Kolb, is "to stand at the interface between social knowledge and the ever-novel predicaments and dilemmas we find ourselves in…to guide us through" and even contribute to the learning of others (Kolb, 1984, p.225).

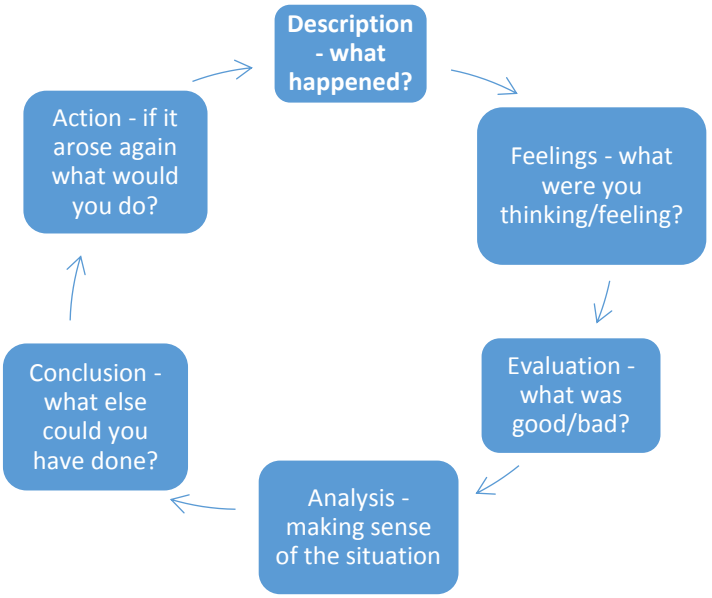
This connects with my research project which I argue develops Kolb's work based on his view of the learning process combining work and personal development. My research project uses a reflective process for HCPs at work, not for their professional development, but in order that they may nurture their wellbeing, in their context. It involves both their knowledge of their experiences and a growing sense of self-awareness, building on the juxtaposition of Kolb's work development and personal integrity.

My project further develops Kolb's application by using my HELP Wellbeing Reflection Cycle. This has a useful acronym in a memorable 4 stage model. It also uses questions at each stage that specifically invite self-awareness in the process of nurturing wellbeing through reflection-in-action. For Kolb and his predecessors, the 4th stage involves action to test out new learning. My reflective cycle develops this stage as a platform for leaving the reflective space empowered, able to return to the workplace, with a greater sense of wellbeing. The new learning, the pondering, is not a solution but an ability to make an empowered step for personal and professional wellbeing rather than any conclusion that cognitively tests new knowledge. (My development of Kolb's work will be re-visited in Chapter 4).

Gibbs (1988) – a 6 stage cycle

For professional development in healthcare a variety of models and cycles have emerged. Likely to be the most familiar to HCPs grew to be named as the Gibbs Cycle. Looking for a "user-friendly" method of reflective practice at Oxford Polytechnic in the 1980s, Graham Gibbs' work on "experiential learning" was adapted for students, both involving and described by Chris Bulman (Bulman and Schutz, 2008, p.225). Here there are six stages, reflecting through describing the event, identifying and exploring feelings, analysing to make sense of the situation. There are then two levels of conclusions, reflecting on possible alternative action and then making plans for future

action (Bulman and Schutz, 2008, p.226). Interestingly, Bulman points out that practitioners need help to become more aware of the reflective cycles to use them effectively (Bulman and Schutz, 2008, p.226).



The Reflective Cycle adapted from Gibbs, Farmer and Eastcott, 1988, 'Learning by Doing' (Bulman and Schutz, 2008, p.225)

As I explore in Chapter 2, in this research project's methodology, my pilot study revealed one of the key problems of reflective practice is the complexity and unmemorable nature of many of the most taught reflective cycles. Although remembering something of the Gibbs Cycle, many of the HCPs from that sample were unable to recall its stages sufficiently to be able to use it ad hoc in the work context.

Johns (2009) – a 6 stage "circle" with 18 "reflective cues"

Johns describes his "critical hermeneutic circle", preferring this to the term 'cycle' which he argues could imply that "reflection is an orderly step-by-step progression" (Johns, 2009, pp.45, 50). His work is developed from his practice in reflection as a nurse and educator. The 'circle' has six stages of internal and

external “dialogue” (Johns, 2009, p.50) between self, the narrative of the experience for reflection, sharing with others, concluding with new knowledge and means of sharing practice and learning. Johns identifies reflection as “a process of self-inquiry and transformation towards realising desirable practice as a lived reality” so that ultimately the nurse becomes a better carer for their patient (Johns, 2009, p.23).

His ‘dialogues’ come from his journaling experience. He describes the first two as “listening to my voice” and as “writing yourself, your body, nurturing your precious unique self”, connecting with his writing in order to gain “meaning in the text and drawing insights” (Johns, 2009, pp.47, 49). The third ‘dialogue’ he calls “the dance with Sophia” which refers to the knowledge gained by his reflection, and the fourth ‘dialogue’ is associated with support from “peers and guides” (Johns, 2009, pp.81, 86, 87). His fifth ‘dialogue’, using his own story, he calls “weaving the narrative” to be the significant place of self-discovery, and the sixth “substantive text”, is now “open to further dialogue” with both the author and those who read it (Johns, 2009, p.94). This links with the place of ‘conversation’ or ‘dialogue’ identified among practical theologians, such as Pattison’s “critical conversation” (Woodward and Pattison, 2000, p.136). This is as means of discovery through the internal conversation between knowledge, understanding/experience and context.

Within this “critical hermeneutic circle” Johns includes his own “Model for Structured Reflection” (MSR) in order to help HCPs “access the depth and breadth of reflection necessary for learning through experience” (Johns, 2009, pp.50, 51). This has 18 questions or prompts that he calls a “reflective cue” going through the experience, its importance and insights, both personal and professional learning. The first of these prompts is “bringing the mind home” meaning to see reflection as “a more meditative activity – a time of quiet

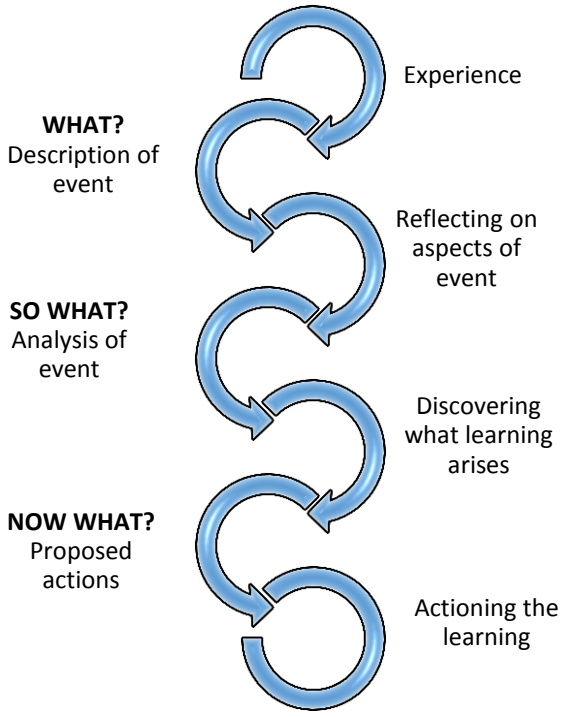
contemplation to pay attention to the self" and the need to "create this space" (Johns, 2009, pp.51-53).

To a healthcare professional these key contributors to reflective practice, colloquially the 'Gibbs and Johns', remain essential tools for professional education and development. This is especially true where detailed reflection is required for clinical higher education (Bulman and Schutz, 2008, p.233). Nevertheless, in the immediate work context of daily practice they are complicated and unmemorable for informal or ad hoc use for HCPs reflection for wellbeing.

Driscoll (2007) – a 3 to 7 stage cycle

John Driscoll's initial work (1994) asked simple 3 stage questions of 'What, So What, Now What?'. He was unaware of their existence in the 1970 cycle of Terry Borton (Bulman and Schutz, 2008, p.227) emerging from his work in American secondary education. Driscoll's own subsequent adaptation (2007) develops this into 7 phases with additional prompts. Here "The What? Model of Structured Reflection" moves from "What?", meaning the event, to "So What?" via describing, examining and reflecting on relevant parts of the event. This moves through this "analysis" to identify the learning from this, onto the "Now What?" stage where action is planned and then undertaken (Bulman and Schutz, 2008, p.227). The additional steps, moving this from 3 to 7 stages, prompt reflection and the next action. However, while possibly helpful to some, the practical additional guides seem to complicate a simple cycle, making it less easy to recall in practice. While this cycle is evident in nursing literature, it is the former two more complex systems that were named, but not recalled in detail, by HCPs in this project. [see over for image]

Representation of image (Bulman and Schutz, 2008, p.227)



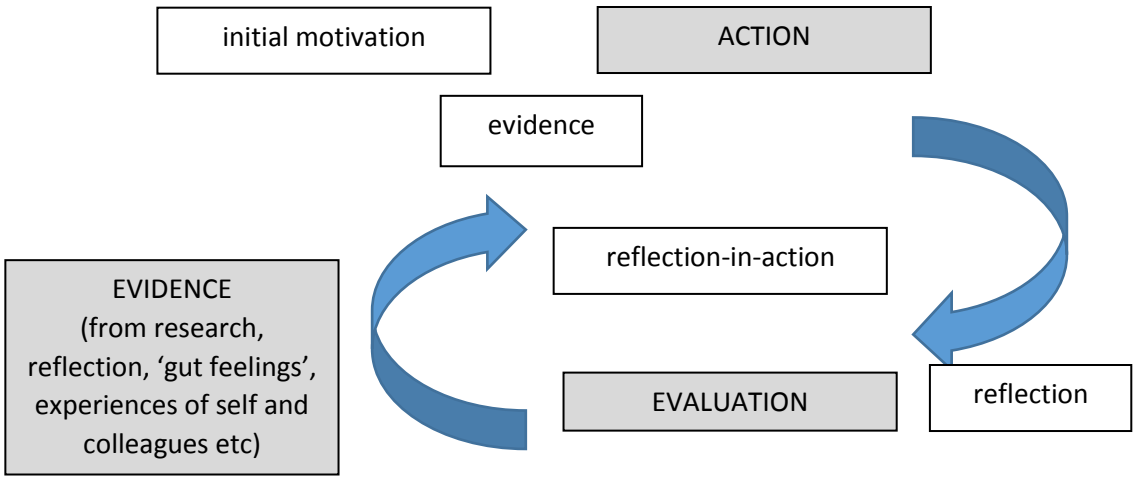
Rolfe (2014) with Rolfe and Gardner (2005) – 3 stage cycle

Rolfe is critical of the way in which reflective practice has developed as a technique in healthcare, for "generating knowledge about our practice by thinking about it retrospectively" (Rolfe, 2014, p.1179). He urges a return to the emphasis placed on "reflection-in-action" (Schön, 1983, p.54):

> Reflective practitioners reflect on-the-spot, in the here-and-now, and the products of their reflections are immediately put into practice in a continuous and spontaneous interplay between thinking and doing, in which ideas are formulated, tested and revised (Rolfe, 2014, p.1180).

So, he calls for nursing, in day to day professional practice, to be a source of evidence-based research and learning with "on-the-spot reflective clinical judgements made in the midst of an evolving practice situation" (Rolfe and Gardner, 2005, p.308). Countering the scientific, evidence based, practice in nursing, they develop Rolfe's model of 'description, reflection, action' for use as the "science of the unique" they propose a process for "on-the-spot

reflective/reflexive…evidence" (Rolfe and Gardner, 2005, p.297). They offer "a reflexive model for evidence based practice" where the situation or event is taken through an on-going 'reflection-in-action' process from the first "evidence" to "action" and "evaluation" (Rolfe and Gardner, 2005, p.307).



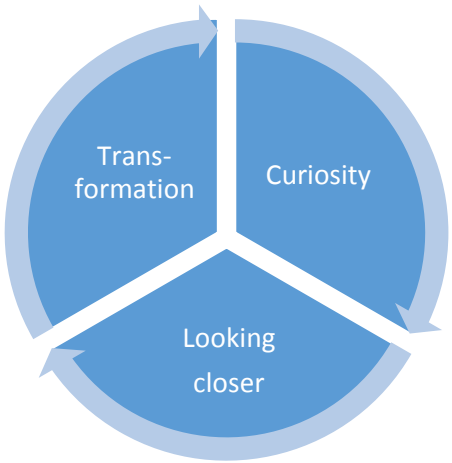
"A reflexive model of evidence- based practice" (Rolfe and Gardner, 2005, p.307)

Defending this drive towards regular, on the spot, reflection Rolfe argues that healthcare's usual *reflection-**on**-action*, after the event, is akin to reliance on the science or "established facts" whereas *reflection-**in**-action* is more like philosophy meaning "reflective thinking…with the curiosity and speculation that arise" (Rolfe, 2014, p.1183). So, for him the HCP can develop by constantly researching, "experiment-in-practice", through the more philosophical reflection-in-action just as a "polemic is not to prescribe solutions, not to answer questions, but simply to raise them and to provoke responses through dialogue" (Rolfe, 2014, p.1183).

My research project adds to Rolfe's work on HCP professional practice by developing the healthcare culture of reflective practice with a simple, regular tool for informal dialogue and shared learning to nurture wellbeing. It facilitates 'reflection-in-action', spontaneous reflection 'on this situation now', in the daily work environment. (My addition to Rolfe's work is developed in Chapter 4.)

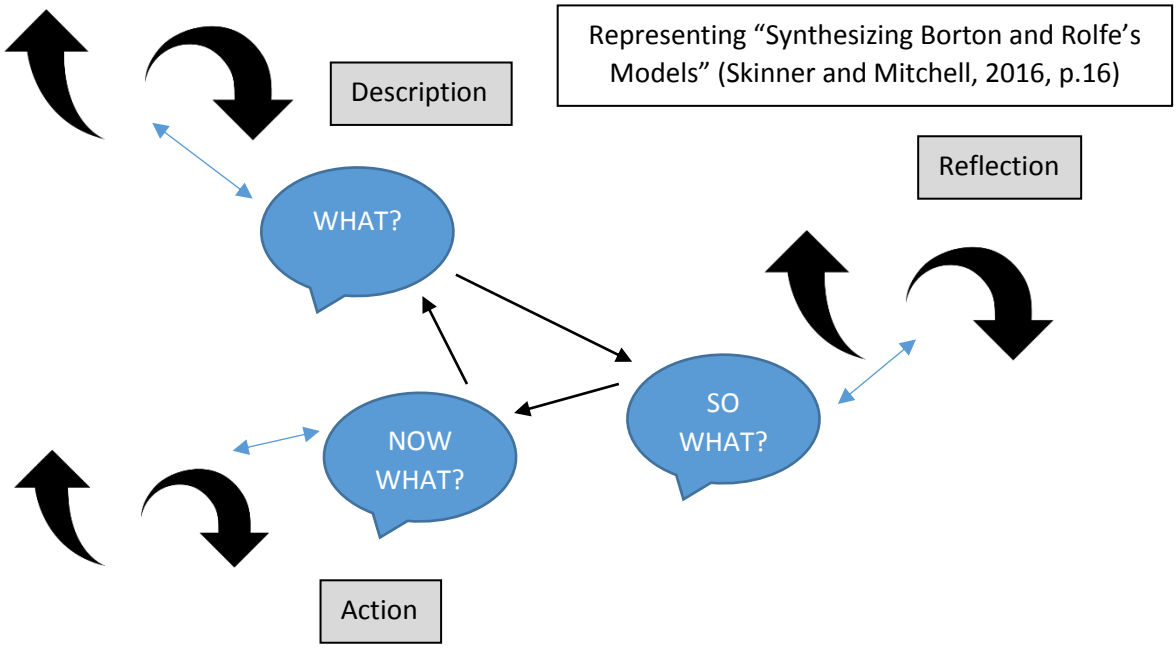
Oelofsen (2012a) – a 3 stage cycle

Writing for the development of reflective practice in nursing, Natius Oelofsen agrees that "organised opportunities to reflect are rare in the busy, pressurised world of frontline practice" (Oelofsen, 2012, p.22). Believing that reflective practice "is essential for improving service quality…support to staff…and…professional development" (Oelofsen, 2012, p.22), he provides a 3 stage cycle. This starts with "curiosity" described as noticing and asking questions, looking at perspectives, feelings and the impact of the event. This moves to "looking closer" in order "to find out more, 'zoom in' on experiences and feelings, 'slow down' their own thinking and actions…"; moving then to the third stage of "transformation" and so "turning sense making into action" (Oelofsen, 2012, p.23). This is a simple and effective process by which he hopes to energize others (Oelofsen, 2012, p.24). In the challenging work of the healthcare environment, the short and memorable reflective cycle is more likely to aid practitioners' use and develop its value.



Skinner and Mitchell (2016) combine Borton and Rolfe – a 3 stage made into 6 stage pair of cycles

For healthcare chaplaincy professional development, Skinner and Mitchell (2016) combine reflective and reflexive practice, meaning with a desire to "generate new knowledge and action" (Skinner and Mitchell, 2016, p.13). They highlight the benefit of flexibility by proposing using either one or other of two cycles, or else working them together by moving in and out of them as required. They describe Rolfe's development of Borton's simple 3 stage cycle (akin to Driscoll as noted) which added "cue questions" at each stage to guide "critical thinking" (Skinner and Mitchell, 2016, p.13). They then advocate the potential to move in and out of each cycle, as required at each stage, either because of the subject for reflection or the needs of those involved. Based on a reflective group the Rolfe "cue questions" (represented as heavy arrows) were needed at some stages and not others (Skinner and Mitchell, 2016, p.16). The combined model is an aid to the facilitator of the reflective session. It supports the view that a simple cycle has benefits in a complex environment like healthcare. However, this model is made more complicated with the 'moving in and out' and for a list of prompt questions.



Illustrative of the background of HCPs reflective practice these examples are for use in professional development. The variety of styles shows both the simple and the more complex reflective cycles. As has been indicated, my pilot study revealed that even the most recognized cycles were hard to recall in their stages, and not sufficient for use ad hoc day to day. If, as will be further argued, reflective practice *is* to be used more widely in healthcare then the more memorable style has more potential for use. Like learning a language, developing the use of 'reflection-in-action' as part of the work culture in the immediate context, part of the routine, would also enhance practice. This project moves towards using reflection in this way, developing regular contextual reflection to nurture HCPs individual and team wellbeing, at the grass roots of their daily work environment.

Developing personal growth

Notwithstanding its key use for professional development and education, this project builds on some of the reflective work in nursing that *has* identified the personal growth element of this learning process. In her work advocating journaling for learning and professional development, Gillie Bolton (2010) sees reflection as "learning and developing through examining what we think happened on any occasion" by "reviewing or reliving the experience to bring it to focus" (Bolton, 2010, p.13). She sees being reflexive as "thinking from within experiences", "able to stay with personal uncertainty" and "the self they find there" (Bolton, 2010, pp.14, 58). So, this is an on-going process of discovery and change, professionally and personally, examining what may be discerned more deeply, the "certain uncertainty" (Bolton, 2010, p.70). Reflection and reflexivity can be an "ongoing constituent of practice" and "a foundational attitude to life and work". (Bolton, 2010, pp.2, 4)

With her emphasis also on journaling, Jennifer Moon explores reflective thinking across education in various professions. She identifies that reflective

practice has significant emphasis in teacher training and as a tool for professional development in nursing (Moon, 1999, p.57). She also recognises that reflection can be an additional tool "to encourage emancipation", a way to see a situation from a wider perspective (Moon, 1999, pp.59, 64). In professions like counselling, Moon notes that reflection is linked with "self-development" but from a place of "deficit" (Moon, 1999, p.88) so suggesting a process of recovery. While this still relates to education and professional development, she explores work in areas of "self-awareness" and "self-improvement" (Moon, 1999, p.82-86). She glimpses the deeper personal value of reflection, suggesting it may be a normal daily process or even help identify "behaviour change" (Moon, 1999, pp.186, 192).

Equally, Wright (1998) argues that reflective practice does have a place for the professional in their own personal spiritual development, unlikely to be totally unaffected by the work and situation (Wright, 1998). So being reflective and reflexive can bring both professional and personal discovery.

The journaling 'dialogues' of Johns (2009) in part mirrors the practical theologian Osmer (2008) and the recognition of the development of the professional practice by developing the internal practitioner. The "challenge of double reflexivity" (Osmer, 2008, p.240) means being willing to see reflective practice for one's professional life as also potentially contributing to one's personal growth.

As a healthcare educator, Taylor (2010) develops her work for all HCPs seeing that in reflective practice one may see that "Ordinariness is the shared affinity we have as humans, which can...give essential humanness to our existing knowledge and skills" (Taylor, 2010, p.103). She identifies that in healthcare one of the most obvious but often ignored features of work is "the familiarity of everyday embodied existence" (Taylor, 2010, p.103) meaning dealing with the intimate humanity of patients. Later Taylor concludes that "honouring

humanity and embodying the qualities of humanness in therapeutic relationships...[can allow] genuine person to person interactions" (Taylor, 2010, p.203). Using reflection in this project, the HCPs become aware of their own humanity as a source of learning. They also recognize the human connection within themselves as a team, and also as HCPs with their patients. The project develops awareness of the reflective space as a pastoral encounter, noticing the shared humanity of HCPs and the chaplain reflecting together. Further, the data will show that the human connection revealed in reflecting together is also part of HCPs measure of wellbeing.

Reflecting together

The experience of the benefits and challenges of reflecting together in this research project will be explored in Chapter 2's methodology and in Chapter 4's reflections. In the literature, group reflection has received a mixed press, from advocating it as a means of supervision and learning together (Carter and Walker, 2008; Bolton, 2010), versus the view that it can be disorganised and needs managing in order to avoid failure (Kelly and Paterson, 2013).

In their work on nurses' group reflection for supervision, Carter and Walker (2008) advise reflective groups to reflect on daily practice for "developing professional expertise" (Carter and Walker, 2008, pp.137, 139). They highlight the risk of authority issues and suggest that that the 'expert' is the one caring for the specific patient whose care they are using for reflection, so the "person-in-context" (Carter and Walker, 2008, p.141). Issues are highlighted to the benefits of group work such as sharing, growth of ideas, creativity and being open. There are also the challenges such as safety, anxiety, effort to keep going, timing, confidentiality and the need for facilitation (Carter and Walker, 2008, p.142). Although helpful, this says nothing of reflection in groups for wellbeing or de-stressing.

Reflecting together has been valued as means of developing healthcare teams "able to sustain high quality, personalised care" (Ghaye, 2005, p.3). This acknowledges, like Taylor (2010), the link of shared humanity, although the phrase "being-human-well" relates to the professional "self...that cares for the patients" (Ghaye, 2005, p.63). My research project however develops group reflection towards the self-support and care within the HCP team.

There is evidence of the benefit of the "small reflexive group" defined as "non-directive, closed group...for reflection on interactions and processes in which reflexivity can take place at a psychological and spiritual level" (Gubi, 2011, p.50). This relies on existing skills of the individuals, commitment to the group, trust, non-judging support of one another and sharing the responsibility (Gubi, 2001, p.59). Moreover, it is also possible to suggest that "collaborative learning is deeply educative, facilitative of empathetic listening and communication, and can therefore be powerfully team building" (Bolton, 2010, p.177). Bolton (2010) advocates group sharing of writing reflections and believes that "collaborative learning is deeply educative, facilitative of empathetic listening and communication and can therefore be powerfully team building" (Bolton, 2010, p.177).

Reflection not supervision

Here, it is important to differentiate between group reflection in this project and supervision. Supervision comes from psychoanalysis and in many professions, including nursing and other caring professions, provides a forum to improve practice with an emphasis on professional development "feedback" (Paterson, 2015, p.154). Supervision is "a form of reflection" involving "reflecting over practice…on professional actions" and is related to professional accountability (Lang and Tysk, 2017, p.134). However, emphasising the value of reflecting within the group for whatever purpose, "inner voices are being joined by all the voices… This means that the space of

reflection offered…will increase with every new perspective that is shared" (Lang and Tysk, 2017, p.135). In the context of this project, group reflection means reflecting togther as peers, sharing the space for listening to one another and learning together. (This will be explored in the consideration of ethnography, participant observation and reflexivity in the methodology in Chapter 2.)

An example of group reflective practice in healthcare was facilitated in a London ITU but the initial support of a chaplain was replaced by nurse educators because "some people experienced difficulty with the religious connotations of his role, and others felt that his dual role as chaplain and facilitator undermined the group's dynamics and trust" (Parish, Bradley, and Franks, 1997, p.1194). This is a rather limited understanding of the role of the chaplain, with a perception that the chaplain will have an agenda rather building space. This will be explored later in this chapter but this project shows that the background of the chaplain is the very resource that they bring to the pastoral encounter of the reflective space.

Theological reflection as a tool of the heart

The phrase "pastoral cycle" is a familiar description of a staged, akin to Gibbs (2008) style, reflective model used for theological reflection. It clearly would include "theological insight" (Cameron, Reader, Slater, and Rowland, 2012, p.5). Theological reflection "enables the connections between human dilemmas and divine horizons to be explored…predominantly a critical, interrogative enquiry in to the process of relating the resources of faith to the issues of life" (Graham et al, 2005, p.6). Of the seven "methods" they identify (for example, personal story-telling, Biblical narrative, traditions of the Church and its relation to mission) the first and most fundamental is "theology by heart" (Graham et al, 2005, p.6). This 'method' "looks to the self and the interior life", using journaling or any means of recording and exploring self-

awareness and experience as "living human documents" (Graham et al, 2005, p.18). They see that "theology from the heart takes us into the depths of self, and the ways in which we grow in knowledge of ourselves as we reflect and seek to understand ourselves 'before the face of God'" (Graham et al, 2005, p.44). Using examples, such as Augustine's phrase "the field of my labours is my own self" (Graham et al, 2005, p.22), this model of theological reflection identifies the value of self-exploration in the search for a deepening relationship with God, or otherness, and in self-awareness.

This method is also identified in "pastoral practice" that "captures the conversation verbatim between a pastoral practitioner and client or patient", giving material for reflection and learning (Graham et al, 2005, p.35). This is for use in professional supervision that includes theological reflection. The value of reflection following pastoral encounters in healthcare chaplaincy, where the narrative may provide material for reflection, is understood as a tool for learning because "pastoral practice not reflected upon is practice that only partially fulfils its potential" (Kelly, 2010, p.48). However, my experience is such that its use and style is very varied geographically and more usually between chaplains. The pastoral encounter as a place for human experience as a source of shared learning, and the post-project use of my research with chaplains, HCPs and pastoral visitor volunteers, will be explored in Chapter 4.

As will also be shown, it is the professional background in reflective practice for discernment that the chaplain brings to the pastoral encounter in the context of acute human experience. Here is the basis on which they offer personal and professional skills, alongside the HCPs in empowering them to make their own discoveries in personal reflection.

Reflection as a facilitated tool in healthcare

In this research project, I am developing reflective practice with HCPs from being a tool for education and professional development towards nurturing personal and team wellbeing. My participants are invited to use a tool that links with reflective skills known to them, regardless of how much or how little they have used reflection before. In my project, reflection is for a new purpose, designed in a simple memorable way, for use in their work environment. As my research project has progressed, I have seen examples of reflection as a facilitated tool for professional development, and whose purpose also *suggests* the personal value. My project however argues for further development of the human wellbeing element in reflective practice.

Terema (2011) 'Human Factors'

In response to a personal human tragedy, the founders of Terema used their background in aviation to develop training in risk and team management, recognising that 'human factors' play a key part in safety. They are a major provider of risk management to the NHS, reporting that 75% of "adverse events" in healthcare involve 'human factors' (Terema, 2011, pp. 1, 2). Part of their training advocates giving time before any event or procedure for "briefing" of the team involved so that everyone understands what is planned. The subsequent "de-briefing" afterwards is in order to "capture learning" (Terema, 2011, p.42). In preparation before the 'briefing' the "bucket management" tool asks the team to respond, each without detail. If anyone has a "full bucket", discovered by asking whether they are "hungry, angry, late or tired", then this is "high risk" raising the question of whether the event should proceed (Terema, 2011, p.25). Here, there is a sense of the humanity of the HCP.

The de-brief follows the AAR model (After Action Review) with 4 stages – "expected – happened – difference? – learned" (Terema, 2011, p.42). This is a straightforward reflective process following a team event designed for professional development. As a training programme 'human factors' urges HCPs to pause, both before and after an event, to consider their particular contribution. This is a form of facilitated team reflection for professional development but takes seriously the human influence.

Oelofsen (2012b) NHS organisation and reflective practice

Writing in a short paper for healthcare management, further to his 3 stage reflective model, Oelofsen argues for a "culture of reflection", to give a "reflective approach to service delivery", making it "the epitome of a learning organisation" (Oelofsen, 2012b). He urges use of reflective practice "to lead to service improvement" with "learning that increases insight and generates fresh approaches and initiatives…" (Oelofsen, 2012b). He argues that reflection in such an organisation should not be like the "power imbalance" (Oelofsen, 2012b) in supervision, but in a forum where people are free to speak and equally heard.

Schwartz Center Rounds®

"In a room of a 100 people, the noisy sounds of lunch hush as the clinical leader..." (Penson, Schapira, Mack, Stanzler, and Lynch, 2010, p.1) sets the scene for the 'Schwartz Rounds'. This is a US project, taken up by UK's Kings Fund, and sold over recent years to several hospitals. It offers "a multidisciplinary forum" and a "model of multidisciplinary reflection" (Penson et al, 2010, p.1). This is to "provide a monthly, one-hour session for staff from all disciplines to discuss difficult emotional and social issues arising from patient care" (The Kingsfund, 2013). This starts with a leading clinician or similar, with a panel of 3 or 4 staff each giving a short presentation of a

significant patient encounter. This is to a large room of staff for plenary discussion, inviting them to focus on connections they make with the experiences of the presentation, to share "insights…vulnerabilities…and support" (Penson et al, 2010, p.1). The inspiration came from the late Kenneth Schwartz who in 1995, through his own experience of illness, found that the humane care he received gave him strength to cope and wondered how the carers themselves found support. The Schwartz Center Rounds in his name were intended "to create an atmosphere that supports…encourages candid participation, positive sharing different viewpoints, and owning emotional issues, and uncertainty" (Penson et al, 2010, p.5). This has been used in the US since 1997 and by several UK hospitals, following piloting since 2013, taken up now by 97 NHS Trusts (The Point of Care Foundation, 2017a).

A 2012 report on the Schwartz efficacy outlines the structure of the programme and the significant requirements:

> …demonstrable support from the trust's chief executive and board; a skilled facilitator available; a senior clinical person to lead the Rounds; dedicated administrative support; a commitment by the hospital to provide lunch for those who attend; a multidisciplinary steering group to plan ahead the topics and cases to be presented, manage the advance publicity for the Rounds, and evaluate each month (Goodrich and Cornwell, 2012, p.5).

It is also intended to be "one way that senior staff and trust boards can signal that care is a priority and show that they recognise the demands on individuals" (Goodrich and Cornwell, 2012, p.7). The report also says there is "evidence from those attending Rounds…that they find them beneficial and want to attend. Rounds do not replace good teams but they do provide space to reflect on the nature of work" (Goodrich and Cornwell, 2012, p.7).

In evaluating their sponsorship of the facilitator training, Macmillan describe their support for staff "to take time out of their caring…to reflect on and improve their practice" (Macmillan, 2017, p.1). They also note the benefit to staff feeling connected to the larger organisation and the verbatim-led large reflective gathering as a "leveller" with multidisciplinary staff attendance, although acknowledge that attendance is "relatively small" in a large hospital (Macmillan, 2017, p.6). Anecdotally, Schwartz Rounds are more regularly attended by those not totally ward based, making them freer to arrange their diary and in the plenary of between 20 and 60 staff many are unknown to each other. These figures are ethnographic but higher figures are shown to be 40 – 140 (Goodrich and Cornwell, 2012, p.6). This is reflection on a large scale, relying on a formal verbatim approach, and takes staff away from their immediate work place. It does not 'create space' for individuals or their own familiar team to develop reflective practice in their own context.

Receiving an innovation award in December 2016 for adapting the Schwartz Rounds, one hospital trust has modelled the "pop-up round", a shorter 30-minute gathering for a ward unable to attend the usual Rounds (The Point of Care Foundation, 2016). These are understood to be advertising the larger event and still use verbatim presentations with visiting panel speakers, with a prepared story of their own rather than from the local ward environment. A further development I suggest *could* involve 'speakers' from the local ward/unit, but this would still require significant time and preparation rather than developing the spontaneous culture of reflecting in the busy local context.

From the Schwartz sponsor is the additional "Sweeney Programme" originating, like Schwartz, from a medical professional with experience as a patient. A programme of training and "techniques…to put the patient's

experience at the heart of the effort to improve patient care" is for "staff to step into patients' shoes and see care through their eyes" (The Point of Care Foundation, 2017b). My project however focuses on the nurture of HCPs' own wellbeing. (Further discussion on the Schwartz' reflection is in Chapter 5.)

Kelly and Paterson (2013) 'values based verbatim reflection' for chaplaincy training and support

In chaplaincy professional development and self-care there is a call for reflective practice because "the primary tool available to a chaplain is the intentional use of the self" (Kelly and Paterson, 2013, p.57). Other chaplaincy research in Scotland includes GP hosted "community chaplaincy" which is "based on the assumption of careful, agenda free listening" (Mowat, Bunniss, Snowden, and Wright, 2013). In the same region, Kelly and Paterson (2013) have developed a model for a "values-based reflective practice". This is primarily for chaplaincy supervision groups, requiring preparation and presentation of a "verbatim" from a facilitator, and following a "rigorous framework" (Kelly and Paterson, 2013, p.56). It uses a "three level of seeing" as their method based on the Resurrection Gospel of John 20, summarized as "seeing…curiosity…when the penny drops" (Kelly and Paterson, 2013, p.61). They affirm the need for structure in group reflection "to avoid moaning or offering advice" (Kelly and Paterson, 2013, p.61). This is indeed a supervision model, relevant for the care and professional development of chaplains, although they suggest it would also be for chaplaincy supervision of healthcare staff. I contend that supervision is for professional development "feedback" (Paterson, 2015, p.154) while my project develops a shared reflective space for nurturing wellbeing. Moreover, the Kelly and Paterson (2013) method requires a rather complex model with preparation and presentation from a facilitator and directive against the fear of the degenerating potential in group reflection. My project is not supervision but

instead advocates empowering HCPs in developing their reflective skills together. My research used facilitated reflections in a relational 'reflection-in-action' encounter, hearing people telling their story, leading to reflection as a self-supporting tool. As the human, vulnerable chaplain, as a reflective companion, a chaplain is taking part in creating, building space for reflection for nurturing wellbeing.

Re-validation for Nursing and Midwifery Council (NMC) 2016

Such is the demand on HCPs to use reflective practice that, from April 2016, nurses are required to include evidence of reflective practice to demonstrate professional development. They must be produced for re-validation of their professional registration every three years (NMC, 2017). They must provide five written reflective accounts, with four questions - describing an event or experience, their learning, their change of practice and connections with their code of professional conduct. This must be followed by a "reflective discussion" with another registered nurse (NMC, 2017). From the guidance for this: "Reflection enables you to make sense of a situation and understand how it has affected you. The reflective discussion should be a positive experience that offers both participants the opportunity to help each other to think about their practice and learn from others" (NMC, 2017). The four questions for the reflective account seem akin to a short reflective cycle but there is no other evidence of further guidelines. As a direct result of my research project, I was asked by several nurse groups (late 2015) in preparation for this to provide a short workshop programme to help them re-engage with reflective practice. In this, I included literature related to reflective practice in healthcare, examples of reflective models, an invitation to prepare one reflective account for group discussion and then facilitating a small reflective group.

These are five examples drawn from evidence that point to the use of, or desire to use, reflection in healthcare. The four that are being practiced each have their particular value in contributing to a more reflective healthcare system. The contrast between them, including exploring further the Schwartz Rounds and this research project will be discussed in Chapter 5. My research project develops these examples of reflection and responds to need, set out in the motivation for this project, at the grass roots of healthcare practice by working towards developing reflection to nurture a more holistic and relational sense of wellbeing.

So far, I have argued for a new understanding of wellbeing *beyond* simply the physical health model and I am arguing for a developed reflective practice to help nurture this, which will also be demonstrated through the methodology and data. Lifelong learning is from the storied nature of human life with reflective practice as a means to achieve 'learning from experience'. From ancient roots to today, this involves re-entering the 'experience' or the story within one's heart and mind and exploring to see what may be learnt. From the differing styles or cycles of 'reflection' the simplest are naturally more easily recalled to be used *ad hoc*, especially for regular 'reflection-in-action' in the daily work context. I argue, which will be seen in the thematic data analysis, that HCPs value this reflective space to re-connect with themselves, their team and their patients, all of which is consistent with the developed understanding of wellbeing.

I now want to show how my project contributes to developing knowledge and practice with the chaplain as reflective companion with HCPs.

Chaplain as reflective companion

"Listening to, interpreting and telling stories is the lifeblood of chaplaincy" (Swinton, 2015, p.300).

"…we improve our effectiveness as practitioners of the arts of ministry by taking time to reflect upon our practice…" (Sullender, 2017, p.105)

If human life finds credibility and connection by the stories of human experiences (Bochner and Riggs, 2014; Swinton, 2015) and if the chaplain's professional life is involved with those stories, then they are contextually at the very heart of human experience. Chaplains are "skilled boundary crossers" whose work is "messy…impure and fascinating" (Pattison, 2015b, p.116). This research project builds the reflective space to hear the human stories of healthcare professionals, and so as co-reflector the chaplain is sharing in that human life. This project builds a reflective space right within the experience of that very real human encounter. Before exploring the notion of the chaplain as reflective practitioner, I want to place this alongside the current focus of healthcare chaplaincy.

The focus of healthcare chaplaincy

Broadly the themes, perhaps inevitably, focus on issues that identify the role amidst challenges to the profession's value. These include provision of spiritual care of the patient, apologetics for chaplaincy in the secular institution, and chaplaincy training and self-development through supervision (Kelly, 2012; Kelly and Paterson, 2013; Paterson, 2015). Other themes include working with critical care and the vulnerable such as paediatrics, in end of life care and mental health, and the development of relationships in spiritual care and multifaith issues in healthcare, demonstrating contextual and holistic 'care for all' (Fitchett and Nolan, 2015; Pye, Sedgewick, and Todd, 2015). Chaplains' support of staff is a key part of the role but its increasingly vital

place should not be underestimated, "helping them process difficult situations and emotions from personal and professional experiences" (McClung, Grossoehme, and Jacobson, 2006, p.151). Chaplains' support of staff underpins this whole thesis. I am arguing that moving towards developing reflective practice to nurture HCPs wellbeing is part of my contribution to knowledge and practice. The call remains today that while "chaplains foster interdisciplinary collaboration...future research needs to address improvements to the chaplain's role within the interdisciplinary team process" (Wittenberg-Lyles, Oliver, Demiris, Baldwin, Regehr, 2008, p.1330).

A recent review outlines key areas of the healthcare chaplain's role internationally (Timmins, Caldeira, Murphy, Pujol, Sheaf, Weathers, Flanagan, 2017) describing it as pastoral and religious care, work in the multifaith context and with some uncertainty in relation to how well chaplains support nurse spiritual care training (Timmins et al., 2017, p.3). They see chaplains as providing "both pastoral and religious support, primarily at crisis point in healthcare" and who are "in a pivotal position to contribute to future developments of faith-based care, spiritual care provision and pastoral support" (Timmins et al., 2017, p.15). They conclude however that at times of "difficult decisions" the chaplain's role will prove important with an increase of ethical issues where chaplains are "key support agents for patients, families and staff during such times" (Timmins et al., 2017, p.16). They advocate chaplaincy research linked with their place "as part of a system committed to holistic health care" (Timmins et al., 2017, p.16). This I argue is part of my contribution to knowledge and practice.

Chaplaincy has been defined as "care involving the intentional recognition and articulation of the sacred by nominated individuals authorised for the task in secular situations" (Cobb, Swift, and Todd, 2015, p. 2). It is in a place where faith is not the main agenda and yet where faith is diversely available

(Gilliat-Ray and Arshad, 2015, p.109). This connects with the public accessibility and openness of the chaplain frequently approached in the hospital by those who would never usually seek contact with the Church. Chaplaincy is an example of public theology, the interface between religion and the public space, the hospital as a new forum for these encounters described as "chaplaincy in the public square" (Todd, 2011).

Here theology is a way of thinking, where for chaplains "theology is their expertise" and as "a source of nurture, challenge and insight" (Pattison, 2015b, p.111, 126) with religion as an example and not an end in itself. This links with the sense of the Church as a resource rather than expecting faithful response (Billings, 2004, p.113). This does not deny the integrity of the faith of the chaplain but invites the insights of faith to provide the language of transformation and change, journeying and discovery. It is a source of new life revealed in the public place. Chaplaincy is the care of the whole person, with "a focus on the ultimate value of the person" rather than how they connect with any other structure or teaching (Pattison, 2015a, p.26). The chaplain is not in the business of active evangelism. Their work is by their presence "standing alongside individuals and institutions to nurture citizenship and human flourishing", to "seek and promote justice for the disenfranchised" with "enacted parables of care and witness" as their "creative endeavour" (Pattison, 2015b, p.126).

The chaplain has also been described as "healer" in this ministry, identifying health as the presence of wellbeing "even in the midst of illness" (Swinton and Kelly, 2015, pp. 183, 181). This is an invitation to the whole of healthcare with the chaplain as a "cultural broker…who facilitates the crossing of boundaries" between different people or "between different understandings of health…different perspectives on the nature of healing, recovery and wellbeing…" (Swinton and Kelly, 2015, p.183). Chaplain is then also "educator,

resource and support of staff…with the…skills to equip other staff to fruitfully inhabit such a health world, deliver person-centred, holistic, spiritual care…" (Swinton and Kelly, 2015, p.183, 184). Finding health as wellbeing "even in the midst of extreme difficulties" (Swinton and Kelly, 2015, p.184) is a significant role for the chaplain. This view clearly supports my argument for healthcare to see a wider understanding of wellbeing and allow for building space for HCPs to move towards nurturing it within themselves.

Linking with the view that practical theology must 'give voice to the marginalized' (Stoddart, 2014, p.144), my research project reveals a ministry to empower HCPs to find regular 'reflection-in-action' as a tool for their own self-care. I have described HCPs as voiceless in the face of low morale and healthcare's institutional understanding of wellbeing focussed on individual responsibility for physical health. I argue that providing reflective space within their own team and work environment empowers them to find their own voice using reflection as a source to nurture wellbeing that is also holistic, relational and contextual. With chaplain as reflective companion it is a unique model of ministry and personal human one.

The unique model of ministry

From the start of my healthcare chaplaincy ministry in 2009 I saw the chaplain having a unique model of ministry – a very particular presence, in an uncertain and changing place, of a particular kind of person. Creating a personal model, initially for various presentations and a chaplaincy course essay, I built on the priest model that had been developed as 'witness, watchman and weaver' (Lewis-Anthony, 2009, p.83). This became my chaplain images of 'explorer, archaeologist and safari guide'. The explorer is a lookout and map reader, helping to see the way. The archaeologist is an interpreter who gently holds, brushes dust away to help see the broken pieces, helping identify the treasure. The safari guide journeys alongside, helping to see,

identify and discover. This is a guide in the wilderness who helps make connections with what was seen yesterday and today. In a different way, evolving a model within this project, I have become more able to articulate a deeper awareness of the personal element of the 'human vulnerable chaplain' in my relationship with HCPs.

A ministry of "being there" (Speck, 1998) has long described chaplaincy as a particular "ministry of presence" and as a "non-anxious presence" (Newell cited in (Mowat, Bunniss, Snowden, and Wright, 2013), that "meets people where they are" (Mowat and Swinton, 2007, p.30). It is a "craft", where the chaplain develops a "quality of presence", so it is a reflexive ministry (Bushell, 2008, p.60). It is a watching listening presence where spiritual care could be called "a way of naming absences and recognizing gaps" – "We might use the image of putting a rope around an area of deserted land in order to allow wildlife to develop and flourish" (Swinton and Pattison, 2010, pp. 226, 234). It means "being present while the other person works it out for him or herself" (Orchard cited in Swift, 2009, p.175). For the "primary skills of the chaplain – [are] presence, listening, empathy, spiritual discernment" (Swinton, 2015, p. 300).

This is a "wilderness ministry" that needs "watchfulness" by "those who stand on the margins who see the wider picture", (Moody, 1999, pp. 15, 22) in this "insecure and uncertain landscape" (Swift, 2009, p.122). It is someone capable of working with a "sense of homelessness, the constant crossing and re-crossing of boundaries, the need for hospitality, the importance of chance encounters" (Moody, 1999, p.23). It is someone "who know[s] what it means to inhabit uncertainty and change" (Swift, 2009, p.169). It is a ministry that may constantly "walk through ordinary doors to spend time in rooms with those whose lives have suddenly become immersed in sorrow" (Swift, 2009, p. 169).

The chaplain is especially skilled in the gathering and welcome nature of the pastoral encounter, in creating that space, and naming the reality. This means developing skills in helping people in crisis tell their story: "Speaking in signs, communicating in the language of silence, preserving the gestures of pain...attempts to let suffering speak" (Walton H., 2002, p.4). It is a person able to work with dialogue that may not involve words, as well as dealing with what is hard to hear, tough conversations and experiences to encounter.

The chaplain is a companion on the way, able to facilitate the discovery that, through anyone's own reflections, one may be able to interpret experiences and develop wellbeing in the face of acute challenge, to "give sacramental recognition to moments of personal crisis" (Swift, 2009, p.167). This means using the skills of one able to notice change and transformation of any kind. This is a person who is sufficiently able to deal with their own story in order to be able to hear the story of others. Being able to hold someone else's story will be explored in Chapter 4.

The reflective companion

The chaplain is a reflective practitioner by the very nature of their own vocational discernment and profession. They have a background in theological reflection which is an essential practice for the developing deep connection between human experience and a relationship with God. This is reflection as a "discipline" which is "a deliberate process of critically interpreting and understanding experience" (Cobb, 2005, p.29). Here reflection is fundamental to daily professional practice, also in vocational discernment, and in self-awareness and wellbeing. Practicing critical thinking, familiar with reflecting for professional and personal development, the chaplain is a resource for nurturing this in others.

For chaplains, reflective practice has been described as a "core skill" using "case studies" for professional development (Slater, 2015, p.66; Swift, 2015, p. 170). It is also part of professional validity in best practice, determining "how to respond to the unique circumstances of certain individuals in particular places and specific situations" (Cobb, Swift, and Todd, 2015, p. 1). Reflection is understood as a tool for chaplaincy "supervision" as means of essential support (Paterson, 2015, p.153). It is described as a tool for chaplains' own development.

However, my project moves towards developing reflective practice with the chaplain as the other reflective practitioner with HCPs. As will be shown in the methodology, this is co-reflecting with the chaplain as HCPs nurture within themselves their own wellbeing. They consider the way in which reflection like this may be developed in their own context. It builds reflective space, where there is a dialogue between HCPs and chaplain which brings together the reflective skills of both professional schools. It is a pastoral encounter of sharing very human stories with a human vulnerable chaplain. It is personal because it is both individual and relational, honouring the richness of their shared humanity. This whole project has been made possible with the familiarity and accessibility of the chaplain's existing and on-going pastoral relationship with the healthcare teams.

The chaplain as a reflective companion also offers the personal human connection by being approachable and realistic, genuine in their own openness and presence. Here also the chaplain is "empty handed" (Swift, 2009, p.175) and the "welcoming guest" of "mutual hospitality" (Walton M., 2012, p.226). Emerging from my portfolio these images have been significant in my reflections on this research project and will be explored in Chapter 4.

From this understanding of healthcare chaplaincy, this project explores the chaplain deliberately sharing in and developing reflective practice, within and alongside HCPs in the context of acute human experience.

Listening to others - the desire to empower

This research project builds space for reflection for wellbeing for HCPs. It is in the context of the pastoral care core skill of listening, as they give voice to their own story through reflective practice with themselves as 'living human documents'. The HCPs, reflecting together with the chaplain as a reflective companion, discover that their wellbeing is also holistic, relational and contextual and not simply connected to the NHS health model. This research project empowers HCPs to build space to reconnect with their own humanity and that of their patients and colleagues. In this way, they are empowered also to see themselves as their own source of wellbeing. In addition, responding to the Francis Report (2013), which asked HCPs to provide greater care and compassion, they are further energised to respond and fulfil such an expectation by using this self-care method of reflecting together.

Objectives and summary of this thesis

So far, I have shown the motivations for this research project to improve staff morale and empower them to use reflective practice for their wellbeing. I have placed my work alongside the human experience and pastoral encounter motifs of practical theology, which will be developed further. Challenging the healthcare understanding of wellbeing I argue for a new and *additional* interpretation as holistic, relational and contextual. I have prepared the ground to argue for a developed reflective practice to help nurture this, beyond its use for education and professional development in healthcare. I show that my project also moves reflective practice beyond its use in

chaplaincy supervision and development towards being co-reflector with HCPs nurturing their wellbeing.

In Chapter 2, I will explore how knowledge is generated in this research project. I describe the research methodology, within action research using ethnographic participation observation with reflexivity. I describe the methods of reflecting together and developing a simple reflective cycle for wellbeing. In Chapter 3, I will show the data analysis that reveals HCPs making the human connection between themselves and their patients, valuing the space to reflect together with the desire for shared team support, shared goal and job satisfaction. This will demonstrate their expression of wellbeing, supported by wider definitions in the literature.

In Chapter 4, I reflect on the process, the use of my 'HELP' reflective cycle, the HCPs response to having the reflective space and the development of 'reflection-in-action' in the healthcare context. I explore the 'creating space', "empty handed" (Swift, 2009, p.175), "welcoming guest" (Walton M., 2012, p.226) motifs of my chaplaincy practice, and the reflective space in the pastoral encounter as a space for learning. I consider my own personal reflexive sense of the human chaplain. I will also demonstrate the change in practice that has resulted from my research. In Chapter 5, I will conclude that my contribution to knowledge and practice is in reflective, practice, healthcare and chaplaincy. I challenge the healthcare understanding of wellbeing from simply 'health' to also being 'holistic, relational and contextual'. I move towards developing a reflective praxis that nurtures this new wider understanding and its value in the healthcare culture. I develop the practice of chaplains in reflecting together with HCPs. Seeing beyond this research project I point to these developments in reflective practice, healthcare and chaplaincy, and for a wider constituency both in and beyond healthcare.

Chapter 2 The Ladder

Introduction

From the Benedictine model outlined in the thesis architecture, I will explore the ladder as the metaphor in this chapter for my methodology. As a step in this research, I will then show how my ontology and epistemology are at work in this project. This will include in relation to knowledge generation theories of interpretivism and social constructivism. This will then be linked to my methodology and the way in which knowledge has been generated through this research. I will show how my action research with ethnographic participation observation are related. I also will demonstrate how reflexivity contributes in, and impacts on, being involved in my research.

The following steps will describe my audit and pilot studies and the development of the research proposal, outlining the methods and their evolving adjustment. Throughout, this chapter signifies my development in research practice and points to this project as a means of generating knowledge. All this is of significance in the steps of my professional and personal development.

Methodology's ladder

Developing his vision for monastic daily lives, St. Benedict's Rule includes the Gospel text "For all who exalt themselves will be humbled, and those who humble themselves will be exalted" (Luke 14.11 NRSV). He believes it teaches that "all exultation is a kind of pride" (Benedict, 1976, p.16). Using the biblical image of Jacob's ladder, as angels connecting with earth, he asserts "we descend by self-exultation and ascend by humility" (Benedict, 1976, p.17). In his 'Finding Sanctuary' Abbot Christopher Jamison interprets the steps on the Benedictine ladder for the 21st century. The ascending steps include having a

serious value of life, a willingness to laugh at one's own foolishness, to listen to others and be aware of their needs, as well as to be patient, and with honesty and integrity (Jamison, 2006, pp.100-107). By this route of self-discovery, we reach the top of the ladder by being true to ourselves. We "come back down to earth, ascending by falling" (Jamison, 2006, p.108). Here the emphasis is defining 'humility' to mean to be "down to earth…realistic, honest and truthful" (Jamison, 2006, p.94) so through self-awareness is the "desire to be rooted in the real earthly self" (Jamison, 2006, p.95).

If methodology is "a rationale for the methods used to gather and process data" (Cryer, 2006, p.70), then the defending explanation would include the steps taken. My research is a process of journeying and discovery, a reflective and reflexive process. The 'ladder' image describes the key steps of my journey through this research. The whole research project uses and develops a process of self-awareness, in both the researcher and the data source, by using reflective practice. The basis for this research journey is in my ontological and epistemological position and these "assumptions" form the basis of the methodology (Mason, 2002, p.59).

My ontology and epistemology

The research theories of positivism and naturalism respectively see knowledge gained either from the logic of quantitative scientific observation or the descriptive, qualitative observation of social context (Hammersley and Atkinson, 2007, p.7). Where positivism relies on following principles, naturalism respectfully observes the natural or real with "fidelity to the phenomena being studied" (Hammersley and Atkinson, 2007, p.7). Within research are also key paradigms or "beliefs" that reveal "a worldview" of the researcher – which are "based on ontological, epistemological and methodological assumptions" (Guba and Lincoln, 1994, p.107). Ontology considers the "nature of reality" and "what is there that can be known about

it" (Guba and Lincoln, 1994, p.108) or "what is worth knowing about" (Koro-Ljungberg, 2008, p.429). Epistemology is the study of knowledge, considering "how do we know what we know" (Koro-Ljungberg, 2008, p.429), "the relationship between the knower…and what can be known" (Guba and Lincoln, 1994, p.108).

I understand my ontology to mean my view of my reality, my view of myself and others, being evidenced and tested in my life. It is then my position in my research (McNiff, 2013, p.27) and through which my world view is formed. My ontological position, the "social 'reality'" (Mason, 2012, p.14) I want to research with healthcare professionals, is that knowledge is gained through human experience, people as 'living human documents' exploring their stories. This includes them making connections with their own development and that of others. It is my belief that a key part of life fulfilment is made possible from experiencing the immense value of being naturally reflective.

I understand my epistemology to mean the process of knowledge-making that develops me and others (McNiff, 2013, p.26) and the way I decide what is knowledge (Mason, 2012, p16). What I want to research, to generate knowledge, is the process of learning from experience as expressed in reflective practice, demonstrating deeper awareness of self and others. This has developed through lifelong experiences of intuitively processing my own narrative. These reflective instincts have been identified, framed, developed and shared, through a career in nursing, then through ordination discernment on to priestly and then chaplaincy ministry. Through personal journeying and professional practice, I see reflection as an internal self-help tool for both survival and growth. However, in both my professions, I have seen reflective practice taught, and expected to be used, but neither nurtured nor lived.

This was a key element to the inspiration for this research. When asked to help with staff morale, I offered to facilitate reflective practice for small groups of staff. Continuing to experience it as a source of liberation and learning for myself, I passionately want to empower others to find whatever may be *their own* discoveries through reflection. In the context of my professional practice, the research project was framed in order to learn if this would be desirable and possible for the nurture of wellbeing for HCPs.

From this, my methodology (or "how we do things", "a journey where we find things out as we go" (McNiff, 2013, p.27)) is a process of exploring the use of reflective practice for wellbeing. I am exploring the potential for its development within the work environment of HCPs. In this context, this is the development of reflective skills to nurture wellbeing for the individual and their team. By reflecting with others, we create the space for shared learning. This is a way in which I continue to learn. This reflective space is also a place for respecting our shared humanity and an openness to learn from each other. My research is an example of "knowledge (as) a living process" as we "generate (our) own knowledge from (our) experiences of living and learning" (McNiff, 2013, p.29). This has been *my* experience throughout this research project and continues to be so in every shared reflective space with HCPs and also with chaplains and pastoral visitors. Thus, the project methodology involved devising the means of creating such reflective spaces.

Generating knowledge through my research

My research creates knowledge by testing out my ontology and epistemology, which informs the methodology. This is through my research question, placing my project alongside the theoretical frameworks I have explored, developing the methodology and methods of the project, and analysing the generated data. From here, knowledge is generated through the collaborative work of chaplain and HCPs, respectively as researcher and

co-researchers. My position alongside the HCPs involved in the project will be explored, demonstrating how exploring my ontology and epistemology can produce valid knowledge through research. I will argue that these elements are at work in my project's development of knowledge initially as an interpretivist meaning it is discovered by exploring subjective human experience. The project however develops towards knowledge created through social construction as we together begin to develop "everyday reality-constructing practices" (Holstein and Gubrium, 2008, p.6).

The research theory of naturalism sees knowledge gained observing the natural or real, within which the term 'interpretivism' has come to be understood as drawing together hermeneutics, phenomenology and symbolic interactionism (Hammersley and Atkinson, 2007, pp.7,8). These may be jointly described as exploring, in context, knowledge from human experience and consciousness at this moment, in these circumstances, from the perspective of those involved. Symbolic interactionism is a means of communicating with one another as "people (who) interpret stimuli, and these interpretations, continually under revision as events unfold, shape their actions" (Hammersley and Atkinson, 2007, p.8). This means learning by becoming aware of the other person's perspective and how *they* interpret the event or experience.

The ontology of the interpretivist then is subjective, an "individually constructed world" (Fox, Martin and Green, 2007, p.15) valuing and discovering knowledge from people in and from their own experiences. However, interpretivist research will involve the subjective experiences of all involved, including the researcher, and so requires reflexivity (which will be explored later). The interpretivist's epistemology is the way knowledge is discovered through this "interactive process" (Denzin and Lincoln, 2011, p.5) seen from the subjective ontology of both researcher and participant. It is a

"sequence of representations connecting the parts to the whole" (Denzin and Lincoln, 2011, p.6). This will mean a forum for individual *and* a variety of subjective points of view.

The RPWs (reflective practice workshops) of this project exemplify this communication and form of learning, developing relationally by seeing one another's perspective. The individual HCPs gather as part of their team, as today's group in the RPW, 'reflecting-in-action' now and in this context. The HCPs show in the data the value and support of reflecting on individual experiences that may either be their own or shared, but hitherto unknown or unacknowledged. This is their valued space to reflect and communicate their own and shared actions and meanings. This is discovering knowledge at the micro level, from the individual subjective experiences, in this place at this time, for those involved.

This learning is hermeneutical because "we do not simply live out our lives *in* time and *through* language; rather, we are our history" (Schwandt, 1998, p.224), seeing things from one's perspective and context. With our life as a "storied existence" (Bochner and Riggs, 2014, p.196) we learn from our own stories and from the perspective of other people's stories. Interpretivism celebrates the "uniqueness of human inquiry" and the "real world of first person, subjective experience" (Schwandt, 1998, p.223). However, the endeavour is to be objective, which creates the challenge of how to do this with human experience (Schwandt, 1998, p.223). This is precisely what is happening within the RPWs as HCPs look at their daily work experience, at that time and context. They try to make some sense of their feelings, what they are learning about themselves and each other, and how those experiences and reflections nurture their wellbeing so that they may continue to work effectively.

In this context, at this stage, I see my research as interpretivist that does not try to remove the subjective risk but uses it by "fully accepting the hermeneutical character of existence" (Schwandt, 1998, p.224). The chaplain and the HCPs are real people, discovering by talking and listening, reflecting together. This raises again the important issue of reflexivity which will be explored later.

The individual, subjective and discovery perspective of interpretivism differs from, but arguably compliments and can develop towards, social constructivism. The latter can be defined as the theory of knowledge generated by people working together where "knowledge and truth are created, not discovered by mind" (Schwandt, 1998, p.236). So, this is knowledge at the macro level where "reality is socially constructed" (Berger and Luckmann, 1991, p.13), people working together to create knowledge that in turn becomes a pattern of behaviour for the wider society. This "socially constructed world" has "a shared social reality" (Fox et al, 2007, p.10) that is constructed and developed through the three strands of critical social movements, language and social processes that bring knowledge (Gergen and Gergen, 2008, p.160). It is "the hows and whats of reality" (Holstein and Gubrium, 2008, p.7). Social constructivism is "a frame of understanding" across a variety of disciplines for research, "a rubric for a mosaic", "a distinctive way of seeing and questioning the social world" and "deals with practical workings of what is constructed and how the construction process unfolds" (Holstein and Gubrium, 2008, pp.4, 5). Here "participants actively construct the world of everyday life and its constituent elements" (Holstein and Gubrium, 2008, p.3).

The ontology of the constructivist sees knowledge as created relative to context, at this time, from "co-constructed realities" and the epistemology is by social interaction, where they make "created findings" (Denzin and Lincoln,

2011, p.98). So, for the interpretivist knowledge is discovered, but for the constructivist knowledge is created and constructed.

My research, I think, begins as interpretivist in so far as I want to discover the issues individual HCPs in their team reflect on and the way this links with their wellbeing. However, it is also constructivist because we then, as co-reflectors, create the knowledge, the 'what and how' of the way RPWs work, how they can be sustained, how to build space for these reflective spaces in healthcare.

The constructivist has "an abiding concern for the ordinary, everyday procedures that society's members use to make their experiences sensible, understandable, accountable, and orderly" (Holstein and Gubrium, 2008, p.375). Having discovered its value within this project my interest, as it progressed and subsequently, is how to develop and sustain reflective practice for wellbeing in the HCP workplace. As will be seen (Chapter 4) with several groups now regularly creating and using this reflective space, I continue to explore and nurture the practice, post research, as it develops in different ways.

I have learnt that both interpretive and social constructivist theories for generating knowledge can work together. In this project, knowledge has been discovered in the subjective reflections of individuals and their immediate colleagues in the small groups of the RPWs. It has been created through the RPWs continued use and growth. Both theories may work together where the "realities" seen are the basis for exploring further or wider issues and where constructivism "impulses (are) infused" with interpretivism (Holstein and Gubrium, 2008, p.392).

The combination of knowledge generation through interpretivist and constructivist perspectives is evident over the longer term also. It has developed across the research project field (the hospital) and adopted by more small groups, making the knowledge more known. This means that the

spreading of the constructed knowledge becomes less to do with the individuals involved *specifically* and more towards developing a wider social practice. So, in its wider context, the knowledge created by the development of this form of reflective practice for wellbeing becoming common practice across the NHS could also be described as constructivist. From a social constructionist view, action research is "world making" and therefore not a description of the world but towards "what the world can become" (Gergen and Gergen, 2008, pp.159, 167).

From exploring how knowledge is created in this research project I will now consider the relation between aspects of my methodology and methods.

Relating action research, ethnography and participant observation

Within the spectrum of action research

Action research refers to a range of processes of knowledge development. It involves "people interacting together and learning with and from one another in order to understand their practices and situations, and to take purposeful action to improve them" (McNiff, 2013, p.25). It is a "family of practices of living inquiry that aims…to link practice and ideas in the service of human flourishing" (Reason and Bradbury, 2008, p.1). It is a "participatory process concerned with developing practical knowing in the pursuit of worthwhile human purposes…the flourishing of individual persons and their communities" (Reason and Bradbury, 2008, p.4).

Action research, as a spectrum of forms of knowledge development, opens the description of my methodology theory that will now be described in more detail. I will also show the relation in my research between action research, ethnography and participant observation.

My action research both discovers and creates knowledge as a partnership with HCPs as participants with the chaplain in collaboration. It is a process, in

context, of shared learning and change. With "practitioners as real-life participants" (McNiff, 2013, p.47) we research together in our shared working context. Action research is "a partnership, a process, a conversation, a way of knowing" (Cameron, Bhatti, Duce, Sweeney and Watkins, 2010, p.36). The "partnership" is between those desirous of "solving a problem" and those "who have an interest in what can be learned from practice" (Cameron et al, 2010, p36-7). Before the project began there was already significant relationship between chaplain and HCPs, hence the request to help with staff morale as the project's motivation. It developed into their contribution to the research, and the testing of my ontology and epistemology. The value of the developing partnership relationship however also means "the research can only proceed at the pace which the real work of the organization or practitioner allows" (Cameron et al, 2010, p.44). As will be seen in the flexibility of the project's RPWs, this had to be the case while researching within the demands of healthcare practice.

This research is also collaborative by the very nature of RPWs with HCPs and chaplain as fellow learners. In sharing in the research, my contribution is to set up the groups in the project, provide the HELP reflective cycle, and then both listen and prompt them to articulate their reflections. They reflect together, and I record their words and phrases in the field notes. We are generating the data together, as I facilitate the use of the reflective cycle and prompt them to reflect on their issues and through their reflections the data emerges.

As participants the HCPs are involved in the RPWs, their reflections as generated data in order to move towards change in their circumstance. This means building space for reflection-in-action in their context. This aims to bring about a "praxis, moving from theory to a regular practice, to improve…marginalized groups" (Silver, 2008, p.106). I describe developing

reflective practice to nurture a new wider understanding of wellbeing in HCPs as my desire through participatory action research. This includes "empowering" and a "process of change" (Silver, 2008, p.107). This is true both of my project's motivation and, as will be argued, of this thesis.

We equally have the opportunity to learn and change where the "methodology to be developed is part of change processes" (McNiff, 2013, p54). This is seen in the flexibility of the RPWs' timing, attendance and venues for example, the use and then cessation of the interviews and the development of the reflective cycle.

Action research is "particular to context" and "relies on understandings that make sense in that context" (Cameron et al, 2010, p.43). As will be seen, the RPWs are contextual to the HCP group in the community of their ward/unit.

I can identify this project as a 'process' in the three phases of inquiry, intervention and evaluation (Silver, 2008, p.104). My initial inquiry was during the audit and pilot study, moving to the project intervention of the reflective practice workshops (RPWs). Action research can be described as working "in cycles" with a "renewed practice or meaning which can be evaluated by a further cycle of research" (Cameron et al, 2010, p.38). I acknowledge that this form of 'evaluation' may appear not to be explicit in the year long data generation of this project. However, as will be shown, aspects of the research naturally evolved such as the development of the HELP reflective cycle and the way the reflective groups worked. Equally the continued development of the reflective practice within the environment of my research project, beyond the time of the project, shows that "action-reflection-action" (Cameron et al, 2010, p.38) continues as a source of learning. Further, most importantly, within the reflective practice sessions of the research project, part of the HCPs' reflections included considering what this reflective space had provided, if anything, in that session. This will be explored in Chapter 3 in the

data analysis but I argue that this provides a sense of the action research process for them, considering what they had gained from this reflective space at that time and in order to continue with their day. I am especially grateful to a colleague who helped develop my recognition of this.

The action research in my project does "generate changed meanings as well as changed practices" and rather than ignoring "the espoused value base of the organization" (Cameron et al, 2010, p.43) it develops it. This is in the understanding of wellbeing and care of the HCPs. My project acknowledges that 'building space' for meeting for reflection in the ward/unit environment challenges the structure of the hospital. Yet institutional life includes meetings within ward/unit bases such as shift handover, team meetings, teaching sessions and multidisciplinary teams. The challenge, having identified the value of reflective practice in the ward/unit, reflection-in-action for the HCPs, is to help the wider structure and culture to see this. Moving from gaining knowledge through being interpretivist in the human experience of the HCP team groups, it becomes social constructionist as the knowledge spreads and becomes wider practice.

The reflexive question of ownership then (McNiff, 2013, pp.47-49) is important for the validity of the data *as we together* test out my ontology and epistemology. As much as I hope to empower HCPs to reflect, for the nurture their wellbeing, it is the data from their reflections that contributes to answering the research question. However, as has been seen and will be explored, I *do* have a place in this generation of knowledge. We discover and create knowledge together, but it includes my own "critical discernment" (McNiff, 2013, p.49) so my self-examination, awareness of my contribution, and a willingness to learn. This reflexivity that shows the place of both the HCPs and my contribution will be explored. Our shared role also links with the chaplaincy model of "mutual hospitality" (Walton, M, 2012, p.226),

explored in Chapter 4. This is where the chaplain is host and guest, and where they tentatively and sensitively create space for the story-teller to share their reflections.

My action research, the creation of knowledge with the HCPs of this project, has been undertaken with ethnographic participation observation.

Beginning ethnography

Ethnography has a variety of interpretations as an approach to research. Developing from 19th century anthropology, *describing* "a community or culture", it has grown towards *researching from within that group* with fieldwork with them over time (Hammersley and Atkinson, 2007, p.2). This is a broad base description that I had understood as meaning having an "interest" in such a group then studying them by "first-hand experience", for "a researcher to get right inside" as participant observer (Mason, 2002, p.53, 55). I saw it also as being "involved in the daily world of the people being studied" (Fielding, 2008, p.282) with data from "fieldwork experience" (Aull Davies, 2008, p.5). However, this rather one-dimensional explanation denies the more significant implications of this research process.

From the contextual, "in the field" research with participant observation, fieldwork produces "unstructured" data from which themes emerge through analysis (Hammersley and Atkinson, 2007, p.3). This involves "interpretation of the meanings, functions and consequences of human actions and institutional practices, and how these are implicated in local and perhaps also wider contexts" (Hammersley and Atkinson, 2007, p.3). This then is knowledge primarily for the people involved but may have further and future value to others elsewhere:

> The task is to investigate some aspect of the lives of the people being studied, and this includes finding out how these people view the

> situations they face, how they regard one another, and also how they see themselves (Hammersley and Atkinson, 200, p.3).

My project was inspired by the invitation to help with staff morale. I wanted to investigate how the local HCPs dealt with the stress of the work environment, how they nurtured their wellbeing. Spending time with the HCPs, the 2 years of the audit and then pilot study, explored their existing knowledge of reflective practice and their current means of supporting each other and de-stressing. The year of my research project, testing my ontology and epistemology, spent time investigating the development of their reflective practice in their daily work culture and context in their team gatherings to nurture a new understanding of wellbeing as part of their daily work culture. As will be seen in the data, within the reflective sessions project we investigated this part of their lives, how they face their work situation, and how they see themselves and one another.

I will now explore the key element in my ethnographic work of participant observation and develop the way in which reflexivity contributes to the involvement and impact on this research. Linking with both, I will then argue within my methodology for the use of ethnographic field notes for data generation.

Participant observation

or "ethnographic participation" (Emerson, Fretz and Shaw, 2011, p.2)

From my initial research proposal, I was aware of being a participant observer of my own professional practice and in its development with HCPs. This meant living and working in relationship over time with the HCPs as my data source. I had understood it to be a "strategy" with a sense of "legitimacy" through being there (Aull Davies, 2008, pp.77, 78). This links too with the chaplain's role of "being there" (Speck, 1998), with a particular "ministry of

presence" both "physically and emotionally" (Paget and McCormack, 2006, p. 27). The chaplain has a regular practice of being a participant observer, the "non-anxious presence" (Newell cited in Mowat et al 2013, p.39), with a relaxed openness, quietly alert to one's surroundings. I had seen and developed this in the pastoral encounter, in creating space for the other to tell their story, as the skills of the chaplain. This I have developed in this research project reflecting on the image of chaplain as the "welcoming guest" (Walton M. , 2012, p.226) as both host and guest in the pastoral encounter. (Mentioned also in Chapter 1, this is explored further in Chaper 4.)

Being a participant observer involves "long term personal involvement" but with participation as the "means of facilitating observation of particular behaviours…enabling more open and meaningful discussions" (Aull Davies, 2008, p.81). This sense of on-going relaxed informal conversations is precisely the 'listening and prompting' that I shared in the RPW of this research project. It also involves considering, and constantly reviewing being either or both participant and/or observer, where observing is key but in a "dialectical spiral", observing in order to see more and develop how to participate (Rabinow 1977 cited in Aull Davies, 2008, p.81).

Exploring this further, I have come to see 'participant observation' as more helpfully described as "ethnographic participation" (Emerson, Fretz and Shaw, 2011, p.2). The closeness of the contact and relationship with those amongst whom the researcher is researching is both my experience in professional practice and in this project. I value the sense of "immersion…access to the fluidity of others' lives", developing a deeper understanding through "being with other people…and experiencing for oneself" their context and influences (Emerson, Fretz and Shaw, 2011, p3). Being involved however does not mean that I ceased to be a chaplain, neither did I become a healthcare professional in their field, not "a member in the same sense" (Emerson, Fretz and Shaw,

2011, p5). However, working together in this way is similar to the multidisciplinary team in healthcare, where the presence and skills of the other contributors are recognized as both equal and diverse.

Working in rural Africa, Swantz (2008) sees such participation as "identification" connecting researcher and their research context, as "an agent of transformation" involving those for whom the change is sought (Swantz in Reason and Bradbury, 2008, p32,33). There is a relationship between the researcher and with those who are both participants and their environment. This was my experience of the RPWs which developed as the groups got to know me more, as they developed their reflections together and as they grew to ask questions of each other. This was research from within, supported by me as a catalyst but one whose presence is acknowledged and welcomed.

The participant observer "needs to be open to learn from others and to adopt a genuine learner's attitude" and where "the researcher and the researched share their knowledge as equals" (Swantz in Reason and Bradbury, 2008, p38). This has been a genuine joy throughout this research project, finding and regularly observing refreshment within myself by reflecting with HCPs. The privilege of being part of their reflections has taught me about them, their work, their own insights. Working with them, they have taught me how to develop my own reflection. They have also developed for me and my own chaplaincy team a sense of adventure in shared learning as I continue to reflect within our own team of chaplains and pastoral visitors.

Swantz develops this sense of shared learning seeing her role as "participant researcher" rather than observer because researching in this way is within a growing "human encounter" where "to gain the confidence of the community" is essential (Swantz in Reason and Bradbury, 2008, p.42). This is creation of shared knowledge, with no suggestion of imposition or didactic superiority but, as Swantz argues, with the "researcher's role…as a co-worker"

who both prompts the reflections but also is focussed on the wider picture of the whole project (Swantz in Reason and Bradbury, 2008, p.42). As such, rather than being concerned about the presence of the research, Hammersley and Atkinson (2007) take the view that the researcher has a "role in the field being studied" (2007, p4). Here, "the observer becomes a part of the observation" and where all present "are inseparable and conditioned by each other" (Koro-Ljungberg, 2008, p.432).

I will now further develop this place of the researcher by exploring 'reflexivity'.

Reflexivity – the reflexive debate

From a reflective background, my initial understanding of reflexivity was to be aware of and demonstrate one's own learning, one's development and change through knowledge and reflection (Bolton, 2010). However, while still relevant, this clearly has far broader significance in the research process.

Reflexivity considers carefully the place of the 'researcher' with 'the researched in their context'. Both the theories of positivism and naturalism are concerned with the endeavour to limit any influence the researcher may bring (Hammersley and Atkinson, 2007, p.13). The perceived risk is that the research, the data, could be influenced by or generated to fulfil the researcher's programme and, as widely argued, both for good and ill, this may include to promote a political agenda (Hammersley and Atkinson, 2007, p.18)

I am mindful that my research project may have implications for a wider audience than my research field. This means not only the HCPs of this project and developing through the hospital in which they work, but potentially creating knowledge for the wider NHS. Reflexively I consider why and for whom this work is being done. Without judgement I wanted to discover

whether the reflective tools that inform and nourish me, professionally and personally, could be of any use to nurture wellbeing in the HCPs of my work place. I acknowledge that I am encouraging healthcare towards a wider interpretation of wellbeing than predominantly related to health. The work to create knowledge through this research was to help nurture the wellbeing in the self-care of HCPs, but also to work with the institution in its care of staff. Further, I wanted to see if I could help my profession contribute to staff support in this way. In all this, I wanted to develop the chaplain's role of accompanying and empowering the other.

However, in contrast to rigid anxiety about any influence of the researcher, I think there is a more realistic and ethnographic view to adopt. Research cannot be done "in some autonomous realm…insulated from the wider society and from the biography of the researcher" (Hammersley and Atkinson, 2007, p.15). Reflexivity as a central feature of ethnography means living with a constant awareness of one's presence within the research project group. It means acknowledging "that we are part of the social world we study" (Hammersley and Atkinson, 2007, p.18), in our sharing and also observation of the world around us. If I am exploring my ontology and epistemology in the context of the HCPs of my workplace, I believe that I cannot avoid being part of this research. However, if the knowledge we create is to be credible I must identify and make visible my presence there. So, what of my place then within this project?

I am interested in empowering HCPs to explore and develop their use of reflective practice for themselves. I am exploring their practice and my practice with them. This is not so much for their professional growth but to see if their existing awareness about reflective practice could be developed for nurturing their wellbeing. In any pastoral encounter I believe a chaplain, with a patient or member of staff for example, would have no agenda save

for empowering the other to tell their story. This is by listening and prompting, making connections, being alongside while the other person discerns their solutions. In this ethnographic research the knowledge is found in the same way, the HCPs as the 'other person' in this reflective encounter. In researching, my "primary goal must always be to produce knowledge" and to "minimize any distortion of [my] findings" that may come from my own views and hopes (Hammersley and Atkinson, 2007, p.18). In the pastoral encounter with a patient, to offer my solution would be detrimental because this would be informed by my story and not theirs. In the same way in the project RPWs, as will be shown in exploring the use of field notes, I need to distinguish between my presence and that of the HCPs. In further analysis this also involves developing the means of checking and reviewing this, rather than creating something that is hoped for but not there. (Data analysis is explored in Chapter 3). While I cannot separate myself from my ontology and epistemology, I need to be aware of it in this objective, self-observational way that is 'reflexivity': "We act in the social world and yet are able to reflect upon ourselves and our actions as objects in that world" (Hammersley and Atkinson, 2007, p.18).

Ethnography, with its key element of reflexivity, is living learning, an on-going journey of discovery. This is the essence of the RPWs within and beyond this project, where the contextual reflection and self-observation on the issues discussed are part of learning. It is true throughout the period of research as a living process, where the research design is also a "reflexive process" (Hammersley and Atkinson, 2007, p.21.) This will be shown in several ways. It includes growing to have several different professions of HCPs in the reflective groups, the flexibility of arranging and running the RPWs, consideration of the value of interviewing, and the development of the reflective cycle.

Being reflexive over time, the value of observing the context and the way people behave (Hammersley and Atkinson, 2007, p.39) is also seen in this project. For example, the pilot study noted a coffee-room culture where the HCPs enjoyed talking together and so the project explored using this in a dedicated space specifically for reflection. This respects their space for a meal break and the value of space, at another time, for reflective practice. Further, through reflexivity it became clear that the work was made possible because of the relationships over time, without which none of it would have occurred. This was with the informal approach though the audit then more structured in the pilot study, and then a regular pattern of reflection together over the year of the project. Over time, with flexibility and motivation, through "patience and diplomacy" (Hammersley and Atkinson, 2007, p.62), this has involved developing the trust of the group being researched (Swantz in Reason and Bradbury, 2008, p.42).

The monitoring of this happens throughout, where the researcher's role and relations with the data source is "as far as is possible, brought under analytic control" (Hammersley and Atkinson, 2007, p.96). As will be explored, it has been the visible process of using my reflective cycle to prompt the stories of the HCPs and listening as their reflective conversation develops. I have noted their topics and phrases, making connections with individual's experiences. These have not been my stories, nor my contribution with solutions or opinion, but space for them to talk and listen to each other. The ethnographic data is as "accounts of themselves and their worlds" (Hammersley and Atkinson, 2007, p.97) so in the RPWs the issues they talk about, how they express it, and their exploration of the deeper issues this exposes. Once again, as in my understanding of chaplaincy, my role is "being alongside them as they work out the answers for themselves" (Orchard in Swift, 2009, p.175). It is a role that constantly re-checks whose story is being told.

Reflexivity is an on-going, living experience, requiring constant self-observation and reflection. Yet this has been called the "narcissistic wound" (Lather in Atkinson et al, 2007, p.486) where reflexivity becomes a self-perpetuating personal sore that, by constant digging, would not produce a whole or finished product of knowledge. More fruitfully, so such a view argues, the reflexivity that "attests to the possibilities of its time yet…registers the limits of itself" (Lather in Atkinson et al, 2007, p486) will have an end result. Ethnography then is a process of living and learning that creates today's knowledge. So, if ethnography is a living process of learning, we can only know what we know now, but as living learning it is an on-going journey of discovery.

Before describing the further progression of my methodology and methods, I will now defend the use of field notes as part of the living learning that is ethnography. (The defence of creating field notes rather than using electronic recording will be explored later in this chapter.)

Ethnographic Field notes

Field notes are a form of qualitative data from both the ethnographer researcher and their data source. A "traditional means in ethnography", also customarily acknowledged as likely to be "selective", the researcher concerned to discover how and what to write, to glean as much of the relevant material (Hammersley and Atkinson, 2007, p.142). In the space and context of the RPW this seemed clear that I was looking for both what they were saying "about events" in their work context, and both how and why they express it (Hammersley and Atkinson, 2007, p.120). This meant the issues they were reflecting on, the topics and themes, their phrases and feelings expressed.

I want to argue for the potential of field notes being just as real as the events that produced them (Emerson, Fretz and Shaw, 2011, p.245). Thus

"ethnographic participation" (Emerson, Fretz and Shaw, 2011, p.2) is a more congruent way of describing the researcher alongside the people amongst whom they are researching. The physical presence of field notes, with the HCPs reflections and my annotations, are an image of the reflexivity of the project. We are reflecting together, both identifiably present on the same page. As genuinely and as openly as possible, this is *our* story.

As will be shown, I used my reflective cycle in the RPWs to prompt HCPs to talk and listen to one another. It was a visible process both in the use of the cycle and my field notes, listening as their reflective conversation developed. In practical terms during the RPWs my writing was in a dedicated A5 notebook at every reflective session and *today's* notes visible to everyone present. Each session started with a new open double-page to protect the data from any previous session. Each RPW's new page was marked only by the date.

My relationship with them was "enabling…open and meaningful discussions" (Aull Davies, 2008, p.81). They were reflecting through hearing their own and each other's voices, seeing and making their own insights and connections. I was observing and sharing their conversation and reflections, participating by prompting further conversation. This would be by re-articulating something that had been said or commenting on seeing connections between their stories. I was noting their topics and phrases, and noticing connections with individual's experiences. I also noted emerging themes.

Field notes demonstrate the researcher's role and their relations with the data source by using written "asides and commentaries" (Emerson, Fretz and Shaw, 2011, p.123) alongside *their* data. In this project their direct words were quoted reflections in inverted commas and any notes of mine as annotations were clear to the side. At the end of each session I read back my field notes

to the group, pointing out their quotes and any comment of mine, to be clear that this represented the reflections and discussion.

Having the data as field notes in the form of a notebook journal, for a year of RPWs, the physical presence of the material was familiar and reassuring. I had a powerful sense that I was both carrying out my research project, with my HCP colleagues in the reflective sessions, as well as 'carrying my research' in the notebook in my hands.

Subsequently quoting thematic examples from the field notes (as will be seen in Chapter 3) endorses, gives structure to, "developing a thematic narrative" (Emerson, Fretz and Shaw, 2011, p.202). These phrases from the data are "essential kernels of the story", as "the core of the story" (Emerson, Fretz and Shaw, 2011, p.203). The themes, with quoted examples, must "create a compelling story line" (Emerson, Fretz and Shaw, 2011, p.206), conveying a visible representation of the people being studied. I use what comes from the RPWs as the voice to tell their story that we shared together in that created reflective space.

This becomes a "record of that experienced reality" (Emerson, Fretz and Shaw, 2011, p.245), our experience of the shared reflective space in this project. My written field notes are woven into the final thesis because "a text about a people's way of life creates that world as a phenomenon" (Emerson, Fretz and Shaw, 2011, p.246).

The field notes have a reflexive value meaning that my voice is "seen and heard" alongside the HCPs. Both our voices are heard because our "interactions in the field shape [my] writing" albeit "inevitably…[my] version…of their version…negotiated and mediated" (Emerson, Fretz and Shaw, 2011, p.246, 247), by both me and the HCPs.

This is real reflexivity; an open kitchen to all involved that shows the relationship between us, and reveals "appreciation and understanding of the interactions that the researcher observes in their, not only his own, terms" (Emerson, Fretz and Shaw, 2011, p.248).

As will be seen, just as the third stage of my 'HELP reflection for wellbeing cycle' invites reflection on learning, so also my field notes involve learning about the HCPs and about me. Further comments on the practicalities of opening the RPW sessions, care of the participants, also the issue of electronic recording, are made later.

I will now show the next steps on my methodology's ladder of the methods used from the invitation to the audit study, from which came the pilot study and thence the research project.

Steps on the ladder - method and tools

Stepping from invitation to audit study

The inspiration for this project started with the initial invitation to help with staff morale on one ward/unit in May 2010. Following this, having provided the first few reflective sessions, I discussed with a more senior HCP whether I could pursue this both on that particular ward/unit and elsewhere in the hospital. She was very encouraging and from her clinical management position also wanted to know what forms of reflective practice may already be taking place across the hospital. At this point reflective practice was beginning to be used as part of staff appraisals. By means of internal communication (generic e-mail and information notices) we invited staff to tell us what, if any, reflective tools they were using and for what purpose. At the same time another member of staff, in occupational health, had been asked to try to create ward/unit team-building group sessions. The three of

us met periodically as the Reflective Practice Forum (2010-2011) inviting staff to join us if they were interested in reflective practice, wanting to share or enhance their experiences. This forum met for only a few months having achieved its initial aim, learning that reflective practice was being used mostly for professional development, de-brief after incident or appraisal in that hospital. The team building work was short lived due to poor response and the re-deployment of the particular member of staff involved.

During this time, I had an increasing interest in wanting to know how much 'reflective practice' was being used at the grass roots level, either by individual staff or within teams of HCPs actually on wards/units. This was both *my* contribution to the Reflective Practice Forum and the pursuance of my increasing sense that reflective practice could be used for *more* than professional development in healthcare staff.

'How're you doing?' Audit *(May 2010 – December 2011)*

The audit, and its development into my pilot study, explored the experience and perception of reflective practice in ward/unit teams of a mixture of HCPs. The audit of this practice was the early work that aimed to introduce the idea of having a reflective session at ward/unit level, and discover their interest, in as wide a field as possible across the hospital. The purpose of this was to gather an overview of the understanding and use of reflective practice by the hospital's HCPs.

In the 2010-2011 audit, with very little research knowledge, the recruiting was random and based on any interest expressed by ward/unit/team managers or staff as I visited their units. In time this included what I now understand to be snowball sampling in terms of "personal recommendations" (Sturgis, 2008, p. 180) as individual staff became aware of my work and invited me to provide reflective sessions on *their* ward/unit.

This random recruiting involved informally approaching individual HCP ward/unit managers, while on my daily routine patient visits, and offering reflective sessions to their team. These sessions I called, 'How're You Doing?' based on my frequently used opening question in many pastoral encounters and the way I had opened the very first sessions in 2010.

With those who expressed an interest I arranged a single reflective session for a time agreed with the unit, for example for some 13.30 or 15.00, on a day that suited best, related to shift patterns and patient visiting. Several wards/units asked me to run this session twice in order to gather as many of their staff as possible. The session gathered several HCPs, as many as were available, at a time in a space in the ward/unit for approximately 20 – 30 minutes. I used a pre- and post-session questionnaire, of 6 questions. In the audit this included a paragraph to explain that this was an enquiry across the hospital into the general use of reflective practice. (In the pilot study the questionnaire included an explanation of my studies in reflective practice.)

The pre-questions briefly asked for the practitioner's existing knowledge and use of reflective practice and also of their personal means of de-stressing at the end of a shift. There were then six presentation slides, with additional pictures, to offer a simple definition of reflective practice using a man in a mirror and then explore briefly the HCPs usual de-stress means. Using my 5-stage re-worded reflective cycle (Fig. 1 p.102*)*, I offered an introduction to reflection for wellbeing rather than the more familiar professional practice. The post-questions asked the practitioner to identify their usual means of ward/unit communication and staff support methods, for feedback relating to their feelings of how this particular kind of reflective practice, as outlined in my session, may be of benefit to their ward/unit in their particular situation.

The session was very informal, creating an environment for free conversation and open reflection and included discussion on all the questions raised on

the questionnaires. There was no obligation to take part, attendance at the suggestion of their unit manager, and anyone could leave the session at any time.

I asked the attendees in each case, when completing the form, to remain anonymous by avoiding writing anything that would identify them in name or job. I would have been aware of the ward/unit from which the paper had originated. It was this verbal consent that was understood in general and approved for the purposes of the potential publishable article (TH8003) by the hospital's then Chief Nurse, as part of my general practice. It was also the senior nursing staff's desire that the HCPs in their units should develop further the use of reflective practice as part of their work culture.

This was an audit of existing professional practice, exploring awareness of reflective practice at grass roots ward/unit level for HCPs. It invited them to consider whether they would use it for wellbeing for themselves and their team. Although I showed them the 5-stage re-worded reflective cycle I was not directly inviting them to use it at that stage. The use of this reflective cycle will be explained under 'research proposal'.

This exploration of existing practice continued as my pilot study, following the same purpose and format, starting the research process.

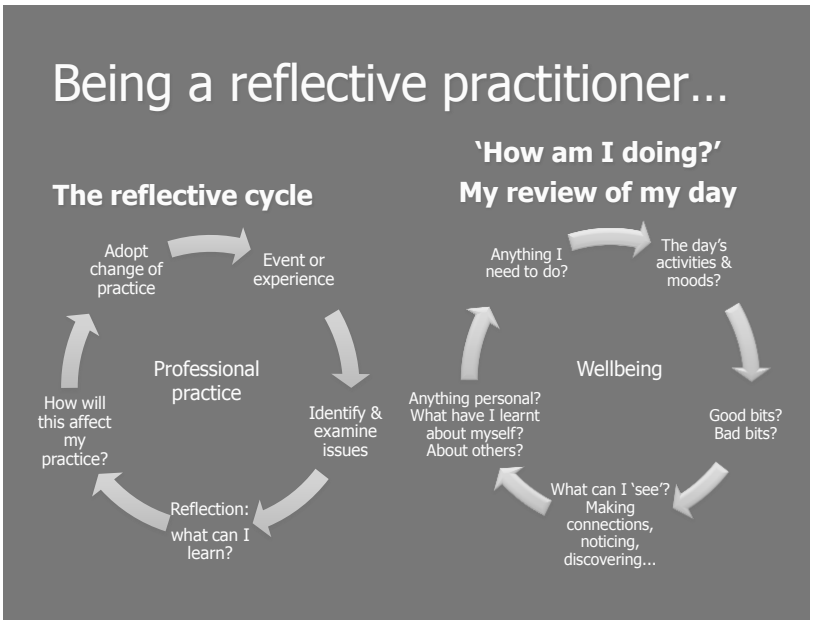


Fig 1 *The development of the reflective cycle from the most familiar for professional development and education (e.g. Gibbs, 2008; Johns, 2009) to my re-worded cycle for wellbeing included in the research proposal.*

Approval – internal and external

The material I generated from May 2010 to December 2011 (referred to as 'audit') was approved by the hospital's two most senior nurses at the time as part of my chaplaincy work, with written approval for research material and potential publication. I then applied for ethical approval for a pilot study for the publishable article module of the doctoral programme in January 2012 from the University of Chester. From this I generated pilot data from January to July 2012.

'How're you doing?' Pilot study *(January – July 2012)*

The pilot study refers to data generated during these dates in 2012, using a revised questionnaire. This incorporated consent, confidentiality and this pilot as an early stage in my doctoral research process. In all other ways the study followed the same format as the audit, outlined earlier. The process followed the same sampling as wards/units became aware of my studies, as they

expressed interest. It also followed the same arrangements for timing and arranging sessions. It continued to develop across a wider number of wards/units and HCPs, to 23 ward/unit teams and over 200 HCPs. I was beginning to gain awareness of how to pursue a research enquiry and so several developments were now in place. Completing an application for ethical approval for the first time highlighted several issues, including the awareness of the need to protect the data source, the researcher and supporting institution(s)! This also developed the questionnaire to provide more information, and the option for me to include it in the data with a more detailed request for consent. The 'risk awareness' made me aware of the need to articulate one's care of the data source. I understood that facilitating a reflective group session, which offers support in dealing with work stress, did not in any way imply any professional inadequacy on their part. Staff were reassurred that if any issue raised in the RPW caused individual distress, a chaplain would be available for confidential reflection and support if desired. Other areas covered and learnt through this included the need for anonymity, attendance without obligation, recruiting based on invitation and staff availability and consent. It also included their freedom to withdraw, non-participation meaning absolutely no detrimental effect on the 24 hour availability of non-judgemental, generic chaplaincy support for them and their patients/relatives.

The most significant contribution of the pilot study was in developing my awareness of the research process.

Conclusions after the pilot study (July 2012)

Both the audit and pilot study, differentiated by adjusted questionnaire and dates used, revealed identical data. Over 50% of the HCPs had received training in reflective practice but only 11% could recall any detail. They described an existing 'coffee room culture', most positively valuing space to

talk, even a brief opportunity to chat with colleagues, space to talk together. This linked with their common practice of thinking things through on the way home and talking to a partner/friend. Together this affirmed that there was room for further exploration and potential development for a cultural shift to use reflective practice individually and for their team. The outline of the audit and pilot study then formed the basis for planning the research project methodology.

The challenges required flexibility in time and space. As will be seen in the data, the consistent risk related to the practicalities of gathering staff together in the face of their work pressures. Shortage of staffing numbers or sudden ward/unit changes were examples of reflective groups being cancelled at the last minute and alternative date/time arranged.

The research project

The next step – data generation April 2013 – April 2014

Building on the audit and pilot studies, I extended the field work in the same hospital for the research project to include 8 HCP ward/unit teams (over 150 HCPs). Having received ethical approval for my research proposal from both University of Chester (January 2013) and the hospital's Research and Development (April 2013), the fieldwork for the research project began in April 2013 and data generation followed for a year until April 2014.

Ethical approval

To protect participants and avoid exploitation, ethical issues are a key part of all research (Fox et al, 2007, p.95) as is also the integrity of the researcher (Gregory, 2003, p.14). Techniques involved include both care of the participant and of the genuine value of the generated data following ethical

principles of power, consent, avoiding harm, privacy, anonymity and confidentiality.

As a practitioner researcher, I needed to be alert and sensitive to the reality of observing one's own practice in one's own work institution and among co-workers. I was also accountable to both the participants and the institution. Participants were made aware of the continued availability of chaplaincy support, outside the research project, should they desire. Care of participants involved being aware of their vulnerability as they explored ways in the RPWs of dealing with a stressful professional life, and any arising personal issues. The anonymity and confidentiality of both data and contributor included the use of the generic term 'healthcare professional' (HCP) but also in the diversity of teams, in differing professions and healthcare speciality. Recruiting a variety of ward/units was by agreement with their manager but ensured that participation was voluntary to avoid feeling of compulsion. The lack of compulsion linked also with the flexibility of attendance and attendees. By the nature of the work environment, no-one could guarantee their availability. Provision to care for these issues, and ensure protection of participants in this research project, were detailed in the successful applications for ethical approval.

Methods for the research project

Reflective Practice Workshops (RPW) – recruiting and sampling

In order to include a wide number of HCPs, through purposive or theoretical sampling to fulfil the research question (Mason, 2002, p.129), I recruited initially 6 diverse wards/units to include non-nurse and non-ward based HCPs. This was by contact with their ward/unit managers. This increased to 8 teams at the request of senior staff to include 2 particular units. The sampling number both seemed realistic in terms of running reflective groups on a

regular diarised basis and over a period of time. In reality the number of teams self-selected, several desirous of following on from the pilot study, asking to continue or join. This also self-generated the diversity of the sort of HCP grouping. In part for anonymising the teams, as well as ensuring sufficient diversity, I wanted to avoid using solely nurses and so committed to calling the data source 'HCPs' and ensuring that the sampling included at least 3 different professional groups and some mixed teams. This also seemed to happen naturally.

I generated data from participant observation, or "ethnographic participation", as a means of "being with other people…and experiencing for oneself" their context and influences (Emerson, Fretz and Shaw, 2011, p.2,3). My use of field notes was as a "record of that experienced reality" (Emerson, Fretz and Shaw, 2011, p.245). (The decision not to record the RPWs electronically will be outlined later in this chapter.)

This was within the reflective practice workshops (RPW) with my re-worded reflective cycle. Initially, as facilitator I also aimed to identify those willing to lead as the groups developed, (noting facilitator skills taken from, for example, Moon, 1999, and Bolton, 2010 and subsequently from NHS facilitator training 2014). This is to explore whether as the practice develops, they may wish, and feel able, to self-lead and self-sustain the reflective practice.

At each session the attendees, voluntarily drawn from staff on duty on that ward/unit on the day of the reflective session, were likely to vary because of shift patterns but each cared for under the same ethical measures employed throughout. This variability represented the same flexibility of the daily challenge of staffing numbers, important if reflective practice is to become part of their working culture.

5-stage re-worded reflective cycle (2010 – 2013)

The audit and pilot study demonstrated an amalgam of familiar reflective cycles (as outlined in Chapter 1) in order to establish the existing awareness of reflective practice among the data source HCPs. I had wanted to adapt the cycle to use words at each stage from event exploration to a more personal or wellbeing reflections rather than professional practice. In order to express this, I described it as 'How're You Doing? My review of my day.' From the outset, from the audit, I described it simply as a 're-worded cycle'. The initial 5-stage re-worded cycle (Fig 1 p102) asked these questions allowing for discussion:

1. The day's/week's activities and moods?
2. The good bits and bad bits?
3. What can I 'see'? Making connections, noticing, discovering...?
4. Anything personal? (What have I learnt about me? About others?),
5. Anything I need to do/follow up in any way?

It aimed to keep to the five familiar stages (event, issues, reflection/learning, change, adaption) but rather than picking over any one event or experience the stages are opened out, with rather more fluid questions, to invite both conversation and exploration of the effect on oneself over the time period being reflected upon. The emphasis is on self-awareness, with the intention to prompt personal reflection, a review of one's day or recent period of time. This, I have suggested, could be used as a personal de-brief on the journey home at the end of a shift and also as a tool for group reflection as a ward/unit team, ideally daily but certainly regularly.

The first stage of the cycle explores feelings and moods through the activities of the day or week, identifying whatever the issues may be, how individuals or the team have been over recent days or how they would describe

themselves or experiences. Secondly, anyone may express thoughts on what has been positive or felt good from the day and *only then* to move on to reflect on the potentially negative, any issues that weigh on one's mind as not good or successful.

The third stage encourages insight, noticing what one can 'see', making connections, reflecting on any sense of discovery, perhaps a better understanding of reasons for action or behaviour, use of skills or coping strategy. This brings the opportunity to speak freely to one another about shared noticing by looking, identifying wellbeing or unease.

The fourth stage invites thoughts on personal development from those situations, learning about oneself and others. The fifth stage explores what may need to be acknowledged as a source for further reflections in any way.

This reflective process follows the pattern of well-known cycles, opening the issues with dialogue. However, it focuses organically on the participant's inner self and wellbeing, drawing out insight and possible conclusions. This self-awareness process encourages exploring a more *personal* perspective in coping with the work challenges in both a reflective and reflexive way. It means not only learning from the experience but being able to identify change in oneself (Bolton, 2010, p.14). It can also develop a more open forum for team communication and team building including identifying skills and issues in and for one another. It draws from the *function* of theological reflection which seeks awareness of self in connection with the transcendent. Here, by using a reflective cycle in a more personal way encourages a sense of self exploration, potentially also nurturing team cohesion. It creates a space for asking one other, 'How're you, or we, doing?'

A *vignette – March 2013*

This first vignette is an example of a RPW using my initial 5 stage cycle in order to provide a more visible image of these events.

"How're you doing?" I gently asked with a smile and slowly looking around the room. Five healthcare staff had come from their unit into the side room for a reflective session with me during the early afternoon just before the visitors were due to arrive. Their body language said it all, with shoulders drooping down and torsos slumped, as they almost fell into the chairs. The conversation continued as they described the busy morning, someone off sick making the staffing numbers difficult on a heavy unit, and the tension of the non-stop pace. After a while, when it felt as though they had painted the scene of the morning I asked if there had been any 'good bits' over the last few days. Someone mentioned a patient who had said thank you, another described his day off, and another spoke about seeing an improvement in one particular patient in recent hours. The discussion continued and after a while I asked, 'And any bad bits?' The chatting focussed on staffing issues, expectations of staff's achievement from senior management in spite of heavy challenges, no-one ever saying thank you at the end of the shift, and their sheer exhaustion. 'Reflecting then, maybe a little more deeply, what can you notice or make connections with, maybe see with further insight...?' We talked about the human connection as a recovering long term patient liked to hold hands with the staff caring for him, the anxious relative who hugged the doctor...the links with personal lives and not only professional practice. One member of staff spoke about her personal issues at home. After a while the reflections drew to a close with a few smiles and plenty of teasing as the staff night-out was being planned for the next weekend. As they left to go back to the unit one of the staff said, 'Thank you, you've given me space to feel human again!"

4-stage 'wellbeing cycle' (from July 2013)

"Do like the wellbeing cycle!" Remark from HCP after RPW (17th June 2013)

By July 2013 it became clear that a simpler 4 stage cycle had evolved. Each 'stage' often easily rolled into the next as the discussion in the workshop developed. Quoting from my research journal:

- For a while I had wondered about the clarity or accessibility of the wording, especially of the second and third (of five) stages in the cycle. I had noted that the first and second stages often seem to run into one another, although my field notes identify them separately nevertheless my journal notes that the discussions around 'the day's activities and moods' either of that day or in recent days (stage 1), often include the 'good bits/bad bits' (stage 2). (From journal 2nd May 2013)
- Changing round the 'good bits/bad bits' – it seems to be more positive way to move on discussion (noted journal 14th May 2013) and in practice within my own team have begun to say 'highs and lows'!
- Changing 'seeing/noticing' to 'insight and reflection' (stage 3) – this has developed because other language didn't seem to elicit much response – I now say something like 'now we've been reflecting for a few minutes, what other insights, about people/situations, would it be worth noticing/talking about?' (noted journal 2nd May 2013)
- I often let the conversation flow, albeit recognizing the 5 stages being moved through, gently, almost unobtrusively leading them through rather than strictly moving from one to next (noted journal 14th May 2013). The reflective cycle was often more of an aide memoire rather than fixed stage process.

I called this the 'wellbeing cycle', with thanks to the HCP's remark. To make this easily memorable I developed the acronym HELP.

The 4 stages

1. ***<u>H</u>ow's today - lows and highs?***

   This is introduced asking in a relaxed open way for general feelings about today's or recent days' work, to explore a challenging event and something that was more fulfilling or fruitful. This invites story, talking about general feelings of today's work, or of recent shifts or events that come to mind. It may be that one event or several emerge.

2. ***<u>E</u>xploring – insight and reflection***

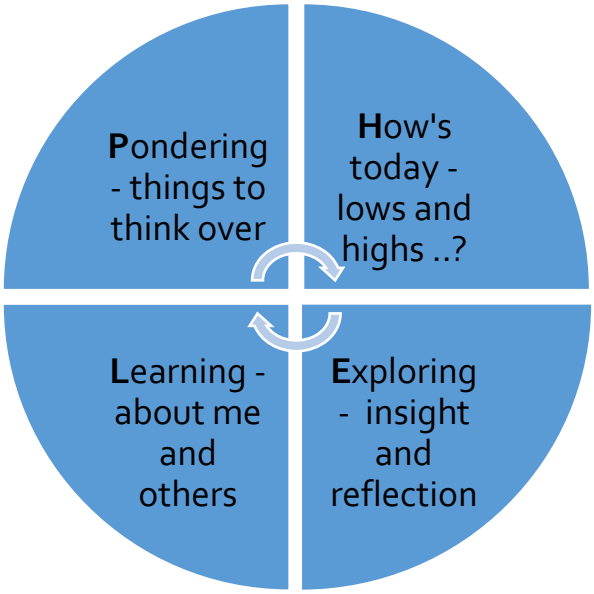
   The reflection may progress to this stage easily without noticing but includes exploring the deeper issues of the experience or event(s), the situation or people, reflections on the stories that have emerged. Prompting to move to this stage is only occasionally needed.

3. ***<u>L</u>earning – about me and others***

   This may be the point where the group needs encouragement to move from the issue to other deeper learning, invited to consider what has been learnt about oneself and others, or where experiences have prompted other thoughts or connections about people and situations.

4. ***<u>P</u>ondering – things to think over***

   The final stage is the summary, the time to consider what one takes from this reflective session, what one may be left thinking about, what difference having this space for reflection may have given. Particular to context, 'What from reflecting on today will make me better at…*N*…tomorrow/next time? What from today will make another day better?'



HELP Wellbeing Reflection Cycle

Fig 2 *The 'wellbeing cycle' with the acronym 'HELP'*

Reflective Practice Workshops

The workshops consisted of from 3 to 8 participants for approximately 20 to 30 minutes. The word 'workshop' is used recognizing the likelihood that different numbers and people might attend each time, rather than a guaranteed same group. Numbers suggested were based on the realistic practicalities of gathering healthcare staff together. Overall the sampling numbers aimed to provide sufficient data and to "be a dynamic and ongoing practice" (Mason, 2002, p.134) meaning allowing for flexibility. I chose these numbers in order to create space for productive reflective conversation meaning that with a minimum of 3 HCPs present there may be a greater chance of dialogue and variety of experience and opinion. From experience with the pilot study and other reflective sessions however I set the maximum attendance as 8 people in order to be able to facilitate the conversation to

ensure all who wished to speak could do so without the group being too large to allow for this.

The reflective sessions were monthly (dates, times and venue arranged with ward/unit manager) for 1 year but to allow for flexibility to become more frequent if ward/unit desired. The length of this project aimed also to indicate whether this could be a self-sustainable regular tool and links with the understanding of "living among the people" for this similar period of time (Aull Davies, 2008, p.77). Once arranged with the ward/unit manager, the sessions were advertised through posters in the respective department, staff made aware that they were under no obligation to attend, and the venue arranged was either an office or other available room within their ward/unit. On occasion dates or times had to be re-arranged due to unforeseen events on that ward/unit or staff availability through work pressure. Alternative or additional sessions were made possible.

A *vignette – April 2014*

This second vignette is an example of a RPW using my evolved 4 stage cycle in order to help provide a more visible image of this practice and to show the development.

"So, how's today?" I asked as the small group gathered and moved their chairs into the middle of the room and as the general natter subsided. This was the second attempt that week to gather people from this particular team following a period of significant reduction in staff numbers and a very busy few days. Among the first few comments someone said it was a lovely day but a busy shift and then the reflections began to emerge with phrases like "keeping each other afloat" which developed into, "It's what it should be like, it's your colleagues that help you!" As the reflections continued there was a lighter feel among them, getting these feelings aired and one HCP remarked,

"Support of each other means you're less stressed." There was no need to invite them to explore this further because the conversation naturally continued into a discussion about the timing of a patient's wash, that while this would be expected to be done in the "morning rush" that there was more "space in the early afternoon" especially if the patient was highly dependent. This returned the remarks to issues of stress – "…because it does transfer to the patient if you're stressed…" and they continue to reflect on the heavy workload at that time. Someone said, "Some days I doubt the quality of care given because we're rushed off our feet." After a moment or two of quiet, letting these reflections hang in the air, I said gently, "What are we learning then about ourselves or other people…?" An HCP said she felt sad because of a patient whose condition was deteriorating, that they had known the patient for a while and her family, "We've bonded, we've connected with her." This feeling of 'human connection' continued in their discussion. After I while, and following a quiet moment, I asked, "So what are you left pondering? What do you take from this session?" The replies were clear saying it had been "somewhere to tip out experiences" and "space to support each other" and they had been "sharing experiences about how to deal with incidents and patient's vulnerability". The final thought was that they had been reflecting on the value of "quality care not rushed care".

Facilitating – opening RPWs

As has been indicated through the ethical 'care of the data source', the RPWs began with making clear the issues of consent and confidentiality. The two documents, participant information sheet and consent form, were given at the start of a session. Thereafter the endeavour was to create a relaxed and informal, conversational atmosphere. Copies of my reflective cycle were on the table or else handed round, depending on the layout of the room.

After general chatting as the group settled, and identifying the time available, I asked, "So, how're you doing? How's today…?" The style of reflection is conversational, relaxed, noting the silence but giving space for all who choose to be able to speak, and to listen. As in any pastoral encounter, I saw my facilitating as listening and prompting in order to encourage the other to continue to tell their story.

Practicalities – use of field notes and not electronic recording

My decision *not* to audio or video record the RPWs was taken because I thought that the participants may find this prohibiting. I was concerned that it would be intrusive, making them hesitant or constrained in speaking. I was concerned they would not have participated so well knowing their conversation was being recorded. Someone taking notes is much more familiar in their healthcare work context.

Ethnographically, before I really appreciated the significance of this, I wanted to share in as natural a group gathering as possible. Developing a continuing relationship with the HCP teams, I looked for a natural and informal context for them to reflect, similar to their shift handover or team meeting. This was firstly for the research project, reflecting together in the context of their work culture. Secondly, I aimed to meet in a format that, as a ward/unit group, they would recognize if they continued in the future.

While recording is understood efficiently to capture the mood and the data for transcribing and checking, note taking is said to be more reflective, helping with a "better yield of analytic themes" (Fielding, 2008, p.274). Also recording "can shape the process of ethnographic work" and so not necessarily to be an automatic means of data generation (Hammersley and Atkinson, 2007, p.147). As I have argued, in trying to create a relaxed and natural space for their reflections, familiar and replicable in style, to have

recorded the RPWs would have inhibited this particular research process. With 8 teams of HCPs meeting at least monthly over a year, and over 150 HCPs, a large amount of data was generated. I was able to check *at the time* with each RPW group, extenuating further my reasons for not recording.

For me, electronic recording in this context felt rather false and imposed. There is a physical reality about using a notebook during reflections, noting our contributions, with a real-time quality to it. This includes being able to check back with them, in that context at that time, at the end of each RPW, that these notes described our reflective group today. This enhanced the participants' voices, empowering them to see and affirm or correct what we had said. My notebook was part of each RPW with my field notes and not an electronic recording tool. I was working in each group, "a role in the field being studied" and not "in some autonomous realm" (Hammersley and Atkinson, 2007, p.4,15). The use of field notes was part of the ethnographic research "as a record of that experienced reality" (Emerson, Fretz and Shaw, 2011, p.245), an experience that we shared.

Interviewing

In order to generate further data, I had also planned in the research proposal to use semi-structured qualitative interviewing of the ward/unit manager and up to 4 of the staff, or up to half the numbers who have attended, (at the first, sixth and twelve month intervals). This allowed for their freedom to contribute by interacting informally with the researcher in a conversation that is "fluid and flexible" (Mason, 2002, p.62). This aimed to discuss their personal and professional development through reflective practice, their view of reflection for wellbeing in healthcare, and explore the effect on their own and their team's sense of wellbeing by reflecting in this way.

However, at the outset I was only able to interview (and recorded with consent) representatives from 4 of the 8 groups due to their time availability. I grew concerned that 1:1 interviewing may only produce positive data, with individual staff wanting to be supportive! Following supervision discussion (October 2013) I concluded that there would be sufficient data in the field notes without the interviews.

The Reflective Community – RPW groups at the end of data generation

My data source has been 8 groups of HCPs (as outlined earlier in this chapter) meeting over a period of a year. As both a data source and as human professionals the effect on them, the contribution they have made, continues to be seen both in their own practice and that of others. Ethnographically they continue to generate data for themselves, in the continued use of reflective practice for wellbeing among them and elsewhere. At the end of the data generation (April 2014/for peer review May 2014) I noted in summary the different ways in which the groups had been able to gather and reflect, and their overall response at the end of the research project, in their differing circumstances.

Summary (May 2014) of variety of responses from the 8 groups (A to H)

A. Dates planned for RPW but often has to be re-scheduled – issues of timing, busy unit, works better with advocate (senior HCP) on duty but when it happens the result is very good, appreciated, although small numbers often – leaving a sense that if time is allowed and work covered then it is well received – HCPs describe as stressful unit and reflection needed

B. Dates planned for RPW but often has to be re-scheduled – issues of timing, busy unit, works better when any of several staff are on duty –

very fruitful when gathered – dealing with needs of individuals and changes in this HCP team

C. Several planned dates and times for group, regular pattern, team's profession expects some sort of reflection – now beginning to explore taking it in turns to facilitate themselves

D. Planned dates and times arranged month by month, evidence of group using this reflective style on other work/team occasions – dealing with both team and individual issues – beginning to consider mix of chaplain support alongside developing own facilitation

E. Dates planned for RPW but initially dates regularly had to be re-scheduled, although better now – initially issues of HCP mix meaning only some grades attended and poor response from others – new energy now following interest of one HCP who advocates for group, encourages people to consider benefit of mixed skill HCP attending – has worked very well since

F. Dates planned for RPW but often has to be re-scheduled – mixed attendance alongside profound issues for unit over long period of time – but well supported by senior unit staff although do not attend – nevertheless several very good individual sessions showing sense of benefit and appreciation of those able to attend

G. Planned dates and times, time allocated – wide attendance because space provided – profound issues on unit beginning to be discussed

H. Significant issues on this unit and senior unit staff recognize need for staff support – group well attended – great deal shared

Reflections on the overall effect on these groups are in Chapter 4, including their subsequent use of reflective practice. I also consider the developing relationship between HCPs and the chaplain, the invitations to support individuals and groups, the growth of new teams and those asking for a return to RPWs in the face of a crisis. I consider also my development of reflective practice teaching post research.

Taking a step back? Professional reflexivity

The essential nature of reflexivity in this ethnographic research project has been explored. This differs from, although compliments, what I now see as professional reflexivity. This is self-discovery, "thinking from within experiences", "able to stay with personal uncertainty" and "the self they find there" (Bolton, 2010, p.14, 58).

This research project is an on-going process of discovery and change, professionally and personally, both in the knowledge created through research but also in my own development. Reflective practice that includes both reflexivity in research work *and* professional reflexivity can be an "ongoing constituent of practice" and "a foundational attitude to life and work" (Bolton, 2010, p.2, 4). This connects with the chaplain's own sense of daily reflective and reflexive practice, reviewing and learning oneself and by peer review the validity of one's practice with the pastoral encounter as a source of learning. This is creating space for checking and re-checking one's ability to be the "empty handed" (Swift, 2009, p.175), "welcoming guest" (Walton M., 2012, p.226). I will return to my own professional reflexivity and professional development in Chapter 4.

In this chapter, I have described the steps of my methodology, how my ontology and epistemology are at work here, and how knowledge has been

generated through this research. I have explored my action research with ethnographic participation observation and how reflexivity contributes in, and impacts on, being involved in my research. I have described my audit/pilot studies and the development of the research proposal, outlining the methods and their evolving adjustment. I have shown the steps of data generation including developing a simple reflective cycle towards nurturing a new holistic, relational, contextual sense of wellbeing for HCPs.

I will now discuss the analysis of the generated data from this research.

Chapter 3 The Windows

Introducing Windows on Data

At the beginning of St. Benedict's Rule, the foundation of his vision for monastic living, he described the community he wanted to establish. He outlined the sort of monks he needed, discouraging those who "spend their whole lives wandering" (Benedict, 1976, p.5), who follow their own purpose. Instead he places value on having "the greatest patience" with one another, "paying obedience one to another" (Benedict, 1976, p.78). Emphasising the value of community, although a challenge, he saw "the experience of interacting with other people" as key to the development of their inner lives (Jamison, 2006, p.117).

The Benedictine vows commit to obedience, stability and "a resolution to live with others", all three vows connected with "community life" (Jamison, 2006, p.116). Obedience means "to listen to someone else", so listening to others and discerning how to respond (Jamison, 2006, p.76). The commitment to share life together in this way, in community, means to be in conversation, listening and speaking to one another, living and working together, relating to one another (Jamison, 2006, p.116). This includes everyone, contributing to individual and community life, because "Conversation is necessary for community to be real…" which "…requires not only speaking but listening" and "sets people free to give of their individual best" (Jamison, 2006, pp.118, 119).

Re-naming St. Benedict's vision for the monastic community for the modern world, Jamison's 'finding sanctuary' uses the image of 'windows' to represent one's own community (Jamison, 2006, p.134). Windows let the daylight into the room, shedding light onto the furniture, making visible what is inside. They also make it possible for someone *inside* the room to look out and take

in the view. They allow the sanctuary builder to see out, to see other people's views, and for the light of the community to shine in. Together with the "walls of obedience", meaning listening, this makes the sanctuary "bright and welcoming" (Jamison, 2006, p.134). Throwing light on the details, the window is a means of exchange or dialogue, a method of sharing information. The window invites *others* to shed light on one's own views.

This is the image for my data analysis, shedding light through the window of this data source community on what they said, looking at the data generated by dialogue in their reflective space. Shedding light on the thematic findings from the data, this chapter draws focus on wellbeing, being also holistic, relational and contextual and how this research process has articulated this in the context of the data source. The later chapters will discuss further the HELP reflective cycle and working towards developing reflective practice to nurture this interpretation of wellbeing.

Making windows – Choosing Data Analysis

In the previous chapter, I explored my "ethnographic participation" (Emerson, Fretz and Shaw, 2011, p.2) in creating data, with the HCPs of this project, and identified the way in which reflexivity has contributed to, and impacted on, my involvement. As I have shown, this has been our shared experience, my field notes recording the data as a "record of that experienced reality" (Emerson, Fretz and Shaw, 2011, p.245). Prior to analysing the data, part of my own reflections considered the difference between the researcher in one's usual practice and then being in the research "setting" (Fielding, 2008, p.275). I was clear that *before* the data generation of this research began (April 2013) I had *already* made what became my research 'setting' into part of my regular practice. This was with the increasingly regular practice of reflecting with groups of HCPs following the initial invitation in 2010 to help with staff morale, on through to the audit and pilot study, to the research project itself.

Therefore, there were no longer two different 'settings' but arguably only one in the context of my regular practice of reflecting in a group of HCPs.

As has been shown, my field notes included written "asides and commentaries" (Emerson, Fretz and Shaw, 2011, p.123), alongside the HCPs' data, which included my identification of early themes. This is consistent with following an "analysis procedure" starting with examining the field notes, noticing themes, finding a means to "mark up" and then "construct outline" grouping data together into the emerging themes (Fielding, 2008, p.276). This was reviewed in a "sequential analysis" (Fielding, 2008, p.279) by reviewing data to find meaning, as will be seen in this project in my 2015 and 2017 analysis. Although this data analysis does include "scrutiny of sequences of dialogue" (Mason, 2002, p.57), the data source however is not necessarily being asked to reveal *why* they say something in particular in the reflective workshop but observing <u>what</u> they have said in order to reveal themes. The analysis is not about the dialogue but to identify the issues raised and topics of discussion. This analysis looks at what the data source is saying in their reflections, and so follows a thematic analysis model (Braun and Clarke, 2006; Clarke and Braun, 2013).

The Window – Colour Coding

As has been described and defended in Chapter 2, the generated data is from the field notes taken during the year with HCPs in the RPW. They record phrases, discussion topics, quoted remarks, noted from their reflections and the group discussion. As part of a 'work in progress' review at 9 months into the data generation (for DProf supervision January 2014 and peer review May 2014) I wanted to identify and document emerging themes. I had begun to recognize increasingly familiar topics, from early RPW, and marked the margin of the field notes as these occurred. I transcribed the field notes

chronologically, at the 9 month stage for review and after the 12 month completion. The themes were first identified by colouring the text and then separating them, grouping them under titled themes.

The first and most visible theme was in phrases related to the human condition (developed here in a later section under 'Finding themes') so I used a red colour font where these phrases occurred in the transcribed data. I then looked for other themes and expected a higher number of stress related phrases or difficult patient relationship issues. I annotated each one with the date of the relevant RPW, and grouped together similar phrases or subject areas by colour. From the first analysis I could easily identify 6 colour coded themes.

The Window - Thematic analysis

Having identified early themes in my data, a more detailed understanding of thematic analysis proved helpful. Defined as "a method for identifying, analysing and reporting patterns (themes) within data" thematic analysis is both a way to embark on analysis of qualitative research data and argued as "a method in its own right" (Braun and Clarke, 2006, pp. 4,6). In this research project, with little prior experience, my colour coding was my own intuitive step into this method of analysis. Having seen an increasing number of mentions in the reflective groups of the link between the patient's and staff's humanity, I was aware that I had to be careful not to assume this frequency would appear conclusively in the data. While encouraging the use of thematic analysis, such as in the ethnographic context of my research, Clarke and Braun (2013) propose starting the analysis reflexively. I demonstrated this in Chapter 2 when I discussed reflexivity.

As an example of an emerging theme, it was only when I first saw what I grew to call 'human connection' in a reflective session that I looked back knowing I

had seen it before. Through on-going reflexivity, I saw its significance in this project. The "active role…the researcher always plays in identifying patterns/themes" can importantly "be a method which works to reflect reality, and to unpick or unravel the surface of 'reality' (Braun and Clarke, 2006, pp.7, 9). Here I was beginning to see in their phrases their 'reality' and the benefit of reflective practice as a means of discernment, to nurture their wellbeing.

Following my initial rather novice colour coding, I looked for a theoretical way to pursue the development of my themes. Guided by the six phases of thematic analysis of familiarization with the data, coding, finding, revising and detailing themes, and connecting this with my research question (Braun and Clarke, 2006, pp. 16-23), I use their titles here. I have, however, swapped the order of 'revising' and 'detailing' the themes. Chronologically I first explored in detail the themes (Jan 2014 and May 2015) and then returned to the data (Feb 2017) to explore more thoroughly the wellbeing theme and consider if any other new themes may be identified.

1. *Familiarization*

Overall, the data was generated from April 2013 to April 2014 and involved 153 HCPs in 8 monthly reflective groups. The initial thematic analysis using the intuitive colour coding began in preparation for supervision (January 2014) and a peer group review (May 2014). Only months later, I realized when looking more closely at my field notes that I had only been looking at data from April 2013 to December 2014. So, beginning to write up my early data analysis (late 2014/early 2015) I saw that there remained data generated from January to April 2014 un-transcribed and unexplored. Perhaps the data had become too familiar or I needed prompting to look at it rather more closely!

This new imperative, to examine the data again and with additional data to explore, helped me see that I also needed to look for evidence of 'wellbeing of staff' in the data to link more directly with the research question.

2. *Coding*

As has been described, from the transcribed field notes, the themes were first identified by colouring the text. Simply due to the practicalities of colour printing, I changed to adding a letter at the end of the phrase to indicate the colour, so for example R for red, G for green. Grouping the phrases into titled themes (for 2014 reviews) I took care to annotate each phrase with the date of the reflective practice workshop. This was in order to check and validate with the data if necessary.

Re-examining the data at the stage of thesis writing (2017) I created a document with all the data under theme headings. This helped develop the selection of examples from the data in order to evidence and explore the themes and their connection with the research question.

3. *Finding themes*

Here the observational and participatory nature of the ethnographic method combines with "identifying patterns/themes" (Braun and Clarke, 2006, p.7) of data analysis. Naming themes within my generated data was evident from the start, listening to HCPs raise their issues for discussion and reflection.

As has been mentioned, the most visible theme from the first few RPW related to the personal or human feeling, whether linked to the HCP, their home or personal circumstance, or else with the humanity of the patient. This human link seemed to be a regular topic, easily identified, and something that the HCPs wanted to discuss. This included seeing beneath the patient's condition, so their situation and needs as reason for mood and behaviour.

This theme also includes the human connection in terms of seeing a shared humanity between patient and HCP. The comparison of 'professional distancing' versus 'human engagement' emerged as a regular feature of each groups' reflections. (This is further developed under the 'human connection' theme later in this section.)

Frequently however the first few remarks at the start of any session involved issues of staffing levels and related professional concerns. For example, in the first RPW for the research project (23rd April 2013) the themes were, in this order, staffing issues/professional concerns (coded green), issues with relatives (coded orange), human connection (coded red), value of team/support shared (coded purple) and value of RPW/space shared (coded blue). These themes are explored in more detail in the following section.

Themes from analysis *(May 2015* plus 2017 numbers/in order of discussion)

I.	Green - professional concerns	(162)	271
II.	Red - human connection	(208)	268
III.	Blue – value of RPW/space to share	(135)	169
IV.	Orange – issues with relatives (+ve/–ve)	(59)	51
V.	Purple – value of team/support shared	(57)	79
VI.	Dark red – issues with patients (+ve/–ve)	(31)	119
VII.	Yellow shading* – wellbeing of staff	(645)	613

Reviewing the data again (February 2017) the actual shape of the RPW, meaning the issues raised and often the order in which these issues were discussed, seem to form a similar shape. Having been able to raise their concerns on matters of staffing issues/professional concerns, the HCPs made a human connection, with themselves and their patients, celebrated the support of the colleagues and the space in which to reflect on their issues.

4. *Detailing themes*

The initial themes were identified for the 2014 review with initial numerical totals for May 2015, were re-evaluated in February – April 2017. Although no additional themes were seen, exploring them in further detail has revealed a deeper awareness of the reflections HCPs shared. Using evidence from the data from each theme supports detailed conclusions to be drawn. The detailed analysis is developed from the first subject often raised in RPWs, as 'professional concerns' combining staffing issues, and examples of exhaustion or stress. Then the significant theme of 'human connection' is explored where the shared humanity has been seen either between the HCP and the patient or the HCP's link with their own personal story in some sense. Recognizing their 'value of the reflective space to share' as the third theme, demonstrates from the numerical evidence that these three together are of significance to the HCPs. The themes then emerge seeing issues with either relatives or patients, and either from a negative or positive perspective. The value of the team and shared support is explored. Finally, the entire generated data was reviewed to see if any data pointed to HCPs' wellbeing.

These following examples, direct from the data, are used in each theme as direct quotes from an HCP or quoted from the way I wrote their words in the field notes. As such they may appear disjointed. This is because I have endeavoured to be true to the data and its source.

I. ***Professional concerns*** (examples from 271 phrases)

Often the reflective session opened with HCPs raising work anxiety or stress issues immediately expressed in their sense of staffing issues, where "Such a culture of being short of staff" (8th July 2013) meant a very heavy workload. The vivid phrases such as "Fully staffed today/ok/other days 'pulling hair out'" (23rd April 2013) and "No-one comes to help us/dragging my body around"

(30th April 2013) contrast with "Fully staffed and fully functional!" (17th May 2013). There is also the frustration of not being able to deliver the standard of care desired without enough help, for example being "Expected to do more with less staff" (5th June 2013) and "pressure causing lower standards" (23rd May 2013). There is undoubtedly a sense of "professional pride" (14th Feb 2014). Here the HCPs correlate low staffing levels with concerns of reduced quality of professional practice, for example "if you have enough staff you feel happier, can get your job done" (12th March 2014) and want to give "quality care not rushed care" (15th April 2014).

They feel unsupported, "Feeling alone in your work" (23rd May 2013) and "Wanted to have done more" (10th March 2014). They feel that reduced standards come from increased pressure, where the "Elephant in the room is the pressure causing lower standards" (23rd May 2013) and that this results in "Signs of stress/reduced self-esteem" (24th April 2014). They "Feel *!?* – not done things I should have done" (3rd July 2013) and "emotionally and physically drained" (30th April 2013). Despite this exhaustion they have a continued draw to sustain care and professionalism – "Will care for you regardless of what you throw at me" (16th December 2013).

Practice also seems to be affected by the perceived quality of the team on duty at any one time, for example with "Got on well/good staffing numbers/team gelling" (29th May 2013) and "Some colleagues when in, you're on edge all the time" (29th May 2013). I noted a conversation on "personalities and behaviour - reflections on professional practice" (11th February 2014) and contrasting "Support of each other means less stressed" (15th April 2014). Equally the lack of leadership, combined with fewer staff, adds to the negative mood: "Atmosphere not wonderful for several weeks – not enough staff/quite a slog/rudderless ship for a while" (4th December 2013).

This connection between professional practice and stress nevertheless links with their sense of their own humanity:

> To be thanked makes you know you've been appreciated - being seen as a person with a name and a life (13th December 2013) and feel guilty you can't be there for all of them (28th January 2014).

Despite it being "hard to pull yourself out of stress situations" (31st March 2014) there is a deep sense of desire to continue to deliver a high standard of professional practice. Yet they need to find space to reconnect with the strength to do so. They remain clear about "being professional enough to deal with but personal enough to care" (16th December 2013).

These 'professional concerns' are powerful in their clarity, also in the paradox of the onerous nature of the work and stress alongside the HCPs' desire and commitment to carry on. If wellbeing is more than health, if it is multi-layered and links with the 'whole person' in their context, then this theme is consistent with this understanding as expressed in this data source. I argue that developing reflective practice in a regular 'reflection-in-action' way gives them space and voice to support each other as professional people in their context, all of which links with this wider understanding of wellbeing.

II. <u>Human connection</u> (examples from 268 phrases)

From the first reflective practice session, after the invitation in 2010 to help staff morale that inspired this research project, I had a sense of the human need of the HCPs amongst whom I worked. Asking them, 'How're you doing?' they said they were so grateful for space to talk and their instant relaxation was palpable. From my research project reflective journal, dated immediately prior to data generation I noted from the on-going pilot sessions:

> Human connection seems to be the theme of the reflections at the moment. Now have done 2 new sessions on *[…N…]* ward in the face of

> stress and high level of complaints. Staff said they feel unsupported and un-thanked, feeling all they hear is the dishing out of complaints and pressure from above to improve. In the first session several spoke of a 'good bit' over the previous few days was a patient's mood lifting when, in a distressed moment (one HCP) hugged the patient and another who held a baby! In the 2nd session several celebrated receiving thanks from a patient and another saying thank you for the joy of a shower as he was improving enough to have one.
>
> In pausing to reflect these staff responded to me identifying the 'human touch' that the patients have felt, which was equally two-way in the fulfilment felt by the staff. Journal 11th March 2013

From here, looking back through the pilot study, I had seen this before. It occurred to me that this is the thread, or the baseline, for exploring the need for HCPs to have this very space to re-find their humanity in order to link with the human patient. During the early weeks of the research project data generation (Apr 2013 – Apr 2014) I began to annotate the field notes, having begun to see this theme emerging. Reflecting on a RPW in June 2013 I had started to make note of the human connection. From the journal, and using the data, I had noted "Recognizing human side" (11th June 2013), seeing their shared human connection and how HCPs had grown more able to see and note the patient's perspective. They reflected: "Changing view of people/things when know deeper story" (11th June 2013) including facing the challenge of "when they're putting you down" (11th June 2013).

From here, I returned to the start of the field notes (April 2013) and annotated the margins with '**H**' where I could see again this human connection and continued to do so, whenever it was clearly present at the time. Further analysis subsequently revealed a growing theme. I was seeing

their value in having the space to reflect on the human and personal in the face of professional challenges.

The HCPs in this reflective space identified the shared humanity between them and their patients: "Sharing humanity – respecting humanity regardless of circumstances" (23rd April 2013). They acknowledge the shared human need, identifying with them, their patients. There is also the sense of the personal giving, the HCP being human too, also sometimes forgetting or feeling prohibited from being human themselves: "You sometimes forget you're allowed to be human" (21st August 2013) and "Good for us all to remind us we're humans" (22nd Aug 2013).

They share a human vulnerability, coping with their own story as well as that of their patients, commenting that it is "easy to forget the illness if that's all you've seen them do" and "that's not the real person" which also "makes me think I shouldn't have been short with him" (3rd December 2013). This goes to the heart of their connection with their own lives: "Palliative care patient reminded HCP of father – quite raw – uniform on makes you feel you shouldn't show it at the time, but time to be aside from it" (21st August 2013). They also describe caring for a "young patient – change in atmosphere – having child of similar age – kept seeing own child – gave own child a cuddle and felt lucky" (21st October 2013).

The recurrent theme was identifying and exploring the balance between being the professional and the human. This means 'professional distancing'; the capacity to face daily the suffering of others, which is the inevitable acute human experience of healthcare, without being overwhelmed; by having the capacity to act professionally; and fulfilling one's professional responsibilities. This was described in nuanced ways such as "Professional distancing versus people who connect" (5th June 2013) and "Happens all the time…something about one of them gets under your skin" (3rd January 2014) where the HCP

has felt some link or connection with the patient and their story or situation for some reason. Equally, it can be "Professional distancing versus care for the other" (11th October 2013) and "Discussion re caring for patient and own emotions, professional distancing and being human" (4th Dec 2013) suggesting genuine care for the other rather than simply professional caring practice but taking care to find a balance.

In whatever way they manage it HCPs are expected to have the ability to care holistically for the human patient, with care and compassion (Francis 2013) and this data shows this, for example, "Seeing them as a whole human being" (23rd July 2013), and "Value of listening to the patient – care of whole person – giving them voice" (21st June 2013), with "Reflection on thinking how patient feels" (10th July 2013). The recognition of the shared human connection provides the key to offering the compassion for a fellow human being. This balance of professional distancing in order to cope with the job alongside making the human connection, and the need to find it, was evident throughout this research project.

The data revealed the HCPs' sensitivity to the patient's situation, how they may be feeling, why the patient's behaviour or response may not be the real person but the ill health directing their response or coping strategy, such as "People kick out because of being distressed" (5th June 2013).

The HCP sees the patient's perspective, and their world in this context. They also see the patient and intuitively make the link with their own life: "Care includes professional distancing and 'this could be my relative'" (2nd May 2013) and "Remind you of someone you know" (29th May 2013). This goes even deeper still with phrases like, "Reminds you how vulnerable you are – connects with own family – our vulnerability" (10th July 13) and with a sense of visceral shock – "Went home, went through it all, close to home, reminds me of things of my own like a whack in the face" (22nd July 2013).

Nevertheless, the HCPs see themselves as the patient advocate, giving them voice, protection, wanting best for their patient, observing occasions when "Angry with doctors who see them as just a procedure" (8th July 2013) and "feel like you've failed him, here to protect him, make him comfortable" (25th July 2013).

Within all of this is also the evidence of the personal self-giving of the HCP, the giving of their own humanity and limitations, and also a fear that a connection can go too far. This theme returns to the need to find the balance between professional distancing and making the human connection: "They're our patients but we're all human beings" (28th January 2014).

If wellbeing is also holistic, meaning links with the 'whole person', then this theme of connecting with the shared humanity of staff and patients is consistent with this wider understanding as expressed in this data source.

III. <u>Value of the reflective space to share</u> (examples from 169 phrases)

These first three themes from the data combine to show the value of the reflective space for the HCP to express and reflect through professional concerns and to reconnect with the humanity of both themselves and their patients. They seemed to breathe a sigh of relief to have this space created, because of the "need to find space to reflect and leave/learn from" (29th May 2013), allowing it to be "less stressful for half an hour!" (30th May 2013). They value the space because it is "Nice that we can open up" (23rd July 2013) and "All the rubbish falls away" (3rd July 2013). It makes them "Feel settled" (22nd July 2013), "like meditation/relaxation" (6th December 2013). They would like there to be space for everyone: "Need to do this with the whole ward" (23rd April 2013).

Valuing the space, they show that it "helps to talk about it" (30th April 2013), expressing their feelings and experiences with colleagues, for example, "Gone

in deeper here" (14th May 2013) and "we've all got vulnerability" (31st March 2014). They value reflecting together as a team, finding support in sharing and learning from each other and together: "You think you're alone in how you feel but knowing someone else feels the same" (21st October 2013). There is also acknowledgment of developing skills to reflect on their own story, for example, "Hearing one another's story helps me reflect on my own" (23rd July 2013) and having "insight into experience of others/how they feel" (17th January 2014).

With space to talk together and support each other comes insight into coping with their workload. It is a place to download the pressure they experience, seeing the "value of place of release" (11th March 2014). It is space to recover the feeling of being settled: "Uplifted/more at peace/bit more positive" (6th December 2013). Here they also re-find their sense of self-worth where "This is time to value ourselves" (5th June 2013) and "Helps to put things into perspective" (3rd December 2013). They express also that they are able to "draw on your own experiences which has helped me being here" (4th December 2013) and that it is "Good to get feelings across/your concerns across" (12th March 2014).

Developing reflective practice in this way gives space for release, to talk, to learn and support, to be refreshed and valued. They are also able to re-engage with the humanity of themselves, their patients and colleagues, and re-engage with their challenging work. It provides "Space to talk about that and be energized to be professional again" (11th October 2013) and so feel "Really glad we've talked more, as we wouldn't have done this" (22nd October 2013). Building this space has the potential to develop reflective practice to be more widely used in this and other contexts, quoting one HCP leaving a reflective session saying, "Do like the wellbeing cycle! It's a way to reflect on the way home" (17th June 2013).

If wellbeing is also holistic, relational and contextual then this theme of valuing space to reflect with colleagues is consistent with this understanding as expressed in this data source. (The value of the HELP reflective cycle and the reflective space will be further explored in Chapters 4 and 5.)

*IV. **Relationships with patients' relatives*** (examples from 51 phrases)

Reflecting on the developing relationship between HCPs and patients' relatives reveals an important value to this reflective space, although showing a lower number of phrases in this data. Here the HCPs have found space to talk over and share their learning together about the complexities of this vital relationship. They describe the challenge of both experiencing relatives who are struggling but also reflect on their concern about how to respond, for example, "Tough relatives recently – bad run over recent months/weeks = rude/anxious – hard to say anything to relieve that anxiety" (10th March 2014). By contrast, they appreciate times where "Couple of relatives thanking for care – how lovely we all are" (30th May 2013). This theme shows the challenge of receiving and responding to the stress of dealing with both a negative and positive demeanour from relatives. Again, their reflections reveal their own insights: "relatives not care about anyone but own relative – but can't blame – value of thinking and seeing how they see it" (3rd July 2013). They share how to communicate good and bad news, and reflect on the value of learning the cause of people's mood, where experiences affect their response: "hard for them to see positive in the face of patient's condition – recognizing their anger, lack of knowledge, fears" (7th October 2013), and "trying to deal with their own grief – don't realize" (12th March 2014).

In this reflective space the HCPs show their insights linked with their own lives and their patients', that as a health worker they are able to walk away from the patient environment. In this example the relatives were complimentary

about the team and the HCP reflected: "…done what you could – all any of us can hope for – end of a chapter, I can put it away (finishing paperwork)" (23rd July 2013). While still able to walk away nevertheless they make connections with families and see the shared humanity. After reassuring a family, one HCP reflected: "didn't take much of my time – alongside when he's a bit anxious – seeing each other's humanity" (6th December 2013). They freely discuss "worrying about relatives/how they're coping" (4th December 2013), and the value of time spent at the bedside not only for clinical reasons: "Afternoon obs. is time to spend with patient and family" (28th January 2014). Reflections also included seeing how also relatives respond to the human HCP: "'It shows you care,' said relative" (10th July 2013), and "We'd been talking about him dying, all die, then relative called (me) out by name – why should they want me? Kept saying thank you" (22nd July 2013). If wellbeing is also holistic, relational and contextual then this theme is consistent with this understanding as expressed in the data.

V. <u>Value of team and support shared</u> (examples from 79 phrases)

Reflecting as a HCP team, the data shows how much they value team work and team support, working alongside, sharing experiences and workload. They reflect: "If I'm not coping, there's someone to talk to (a colleague)" (23rd April 2013) and note the contrast of a "challenging week last week but better this because team is nice" (11th February 2014).

It means appreciating when team cohesion works well, the benefit of working alongside those on whom one can rely, working together, "Drawing on other people's experiences" (2nd May 2013) and caring for each other. They also reflect: "Actually working with someone you know and trust and rely on makes it better, just work together, makes a rubbish shift better" (3rd July 2013). Within this there is the appreciation of "Team work – makes day run smother – communication's good" (11th November 2013). Connections with

each other are really appreciated: "A new thing to be asked if I'm ok…real value when someone does" (11th November 2013). There is a vulnerability and yet closeness in the support of each other such as "Thank you for looking after me" (6th December 2013) and "This is like a small family' (13th December 2013).

They reflect that good quality team support is an invaluable resource, with "Team dynamics up in last few months/more fun/ mood up" (17th May 2013) and "Good relation between/teamwork/nicely ticking over – wish more days like this" (29th May 2013). It is clear that the actual team-player element of the HCP's work is highly valued. They describe "Celebrating increased support, structure, bonding" (11th February 2014) using the research reflective space and they "valued chance to chat, reflect on today's shift, team support" (17th February 2014).

However, the data reveals that these phrases related to 'team' are the second lowest in number (lowest being 'relationships with relatives'). So, while highly valued, as demonstrated by their reflections, there is less evidence of the number of times they experience it. This will be explored later in relation to the theme of 'wellbeing of HCPs'. However, if wellbeing, in addition to health, is also holistic, relational and contextual then this theme is consistent with this wider understanding.

VI. <u>Relationships with patients</u> (examples from 119 phrases)

While this theme links with the earlier 'human connection' and 'professional concerns', their phrases further demonstrate the HCPs' awareness of this complex interface. They witness patient behaviour, for example the frightened patient being aggressive: "Patient's behaviour – lashing out/stressed, frustrated/can't express/scared" (30th April 2013) and their

"reflections on why patient behaves the way they do" (21st June 2013). These contrastingly include seeing the happy grateful patient expressing valuing their care: "Nice when they've gone then send a card to say thank you" (30th April 2013) and "called nurses 'angels on wings'" (3rd July 2013). This combines with seeing the effect on the HCP at both ends of the patient spectrum such as, "awful, dreadful shifts, very difficult patient, stressful as patient deteriorated" (21st August 2013), versus "happy patient, calm, so feeling good job done" (5th September 2013). They express feeling that patient demands are "physically draining versus mentally draining" (10th March 2014). This theme shows HCPs' insight into patients' varied experiences, behaviour and response: "Patient winds me up/very demanding/hotel mentality/could be due to fear, anxious" (8th July 2013).

Their work includes being the possible go-between with patient and relative as well as patient advocacy working with medical staff: "medics not making decision…need to be advocate for him" (8th July 2013), and, "Patient today doesn't have a say in it versus those for whom it's what they want" (22nd July 2013). They show the value, both benefit and risk, of connecting and engaging with the patient, including a feeling of sensitivity towards them. Contrasting the immense challenge of the work is their heartfelt view of it as a continued privilege and with a professional desire to care. They reflect: "good to see improvement…feel I've helped him a bit, nice to share the journey" (21st August 2013), and, of a patient going home "hugging him goodbye, gratefulness you get back from them when they're so happy" (22nd August 2013). Further, they see the effect on themselves of the "challenge of patient's increased awareness of deterioration" (11th October 2013).

In the permanent environment of ill health, dealing with contrasts and uncertain outcomes, the HCPs show a depth of engagement with the holistic nature of healthcare. This is vividly shown with reflections such as "Main issue

reflected on was horrific but a privilege" (25th July 2013). By having space to tell their own story, to reflect on their experiences, HCPs both humanly and professionally are then able to return to the challenges they face. So once more, linking with the earlier themes, if wellbeing is also holistic, relational and contextual then this theme is consistent with this wider understanding.

VII. Wellbeing of healthcare professionals

For the purposes of chronology, analysis of this theme is explored later (p.142) in this section.

5. *Revising themes and connection with research question*

In the final analysis (2017), exploring the data for the possibility of more than the themes originally seen, I reviewed the data phrases under existing 2015 theme headings. With revising attention, I re-allocated phrases that fitted better elsewhere also noting those that had not been allocated to a theme before.

The same 7 themes remained, albeit with a slight variance in the number of phrases from the data allocated to each. For example, 'human connection' grew from 208 phrases in the 2015 analysis to 268, and 'professional concerns' from 162 to 271. It was clear that reviewing data in a "sequential analysis" (Fielding, 2008, p.279) to find meaning and work to familiarize and revise analysis is important (Braun and Clarke, 2006). While in the 2015 analysis, 'human connection' gave the highest score, now in 2017 'professional concerns' achieved a slightly higher number. Perhaps having noticed 'human connection' I saw it more easily in the initial analysis but later recognized that the 'professional concerns' was often an early and dominant reflection in the RPWs. Also 'relationship with patients' was significantly higher than initially thought (31 to 119). This became clearer in seeing more

of the connection with the patient, both in the human sense as well as professional.

Having already identified the initial 7 themes I was aware that, in order to see clear evidence of wellbeing in the data, I needed to re-analyse this theme against a clearer means of identification. In revising this analysis, and to answer my research question, I developed a 'wellbeing definition' tool using a summary of material from the literature, shown below.

Wellbeing as also holistic, relational, contextual – definitions as tool for data analysis (2016-17)

1. Wellbeing as an organic multi-layered experience, "an optimal state", for individuals and communities (Mathews and Izquierdo, 2009, p.5)
2. Wellbeing connects feelings, life fulfilment and the way of self-assessing life issues (Deiner and Biswas-Deiner, 2008, cited in Atherton, 2011, p.7).
3. Wellbeing also connects with the culture or context in which anyone lives and works (Miles-Watson, 2011, p.133)
4. Wellbeing includes working with "someone with a shared mission" and spending "time with people and teams you enjoy being around at work" (Rath and Harter, 2010, p.29)
5. Wellbeing can be measured by "life satisfaction", "feeling what one does in life is worthwhile", "happiness yesterday" and "anxiety yesterday" (ONS, 2014, pp. 1,2).
6. Wellbeing is "the incremental building of networks of relationships and human connection, self-esteem, self-belief, meaning, value and good relationships" (Webster, 2002, cited in Swinton and Kelly, 2015, p.181).
7. Wellbeing "has to do with feeling at home with one's true self irrespective of one's circumstances and recognizing that one exists in

and is part of a context or story that is greater than oneself" (Swinton and Kelly, 2015, p.181).

Using a variety of definitions of wellbeing from a wider arena, I wanted to see if the HCPs demonstrated links in their reflections with any of these interpretations. The first 5 of these definitions are from the theoretical frameworks in Chapter 1 of this thesis. I added two further definitions from healthcare chaplaincy literature.

I will outline the early analysis of this theme, and then re-explore the data against this tool. I will demonstrate that the wellbeing theme, arising from the data, develops a wider understanding beyond only health. It is important to note that this thesis incorporates 'also' in this wider sense of wellbeing – not denying the 'health' model but arguing for a broader, more compassionate awareness of the organic reality of human experience, where wellbeing is also holistic, relational and contextual.

Wellbeing of HCPs *(examples from 300 re-coded from 613 phrases)*

This theme is the most significant and widest subject in this research project. Initial analysis showed that HCPs express the mix of both low morale alongside lighter moments, even notable better times. They share both frustrations and times of putting on a brave face, times of feeling alone and occasions of support, of the contrast of good and poor achievement. The reflection, "did best I could, felt annoyed, frustrated" (3rd July 2013), contrasts "Privilege to work here" (23rd May 2013).

They record highlights of nourishment in both physical and psychological terms, including the place for humour, such as, "One good thing when these things happen we have a laugh" (3rd July 2013). Getting meal breaks is an issue when staff numbers are low and workload heavy so phrases like, "Been to lunch and had cup of tea!" (5th June 2013), are telling alongside

"Chocolates recently!" (23rd April 2013). Also, there is a sense of relief where "Venting is good!" (22nd August 2013).

The HCPs are lifted by patient improvement and by valued colleague support, for example, "Sudden recovery/nice to be surprised" (17th May 13), and "Experienced…team keeping situation safe" (17th June 2013). They face the challenge of human frailty and want to fix it, looking for positive professional practice and good outcomes in the challenge of the environment in which they work. Contrasting examples are, "happy patient, calm, so feeling good job done" (5th September 2013), and "Feel let down patient or colleagues, usually a controlled environment so a very rapid deterioration unexpected/unnoticed" (17th June 2013). They reflect they "wanted people to be treated like humans" (25th July 2013), also that it is a "hard environment to cope" (23rd May 2013), and there are occasions where they "need to rush a job because of feeling called to something else" (30th April 2013).

They recognize and appreciate space to air and reflect on all this. They describe "tapping into each other's experience" (14th May 2013), and "seeing things from other's perspective" (12th July 2013). They learn from each other with the ability to "take away stories and apply in one's own context" (11th June 2013). They are also "looking for [a] forum to discuss concerns re colleagues' style or behaviour" (12th July 2013). Moreover, they look for time set aside for this because they "wouldn't talk over this at lunch" (22nd July 2013), and value space they have at other times, "using walk home to be stress-free" (30th May 2013).

For the re-analysis of the data for this theme, I used the wellbeing tool as outlined above, re-examining the first 300 phrases of the initial allocation. This provides a much broader picture through their reflections on their experience and practice. Initially, I tried to allocate only one of the 7 definitions of wellbeing to each phrase. This was possible for the first 37

phrases but I then realised that more than one definition could be applied. By the 128th data phrase in this theme, I saw 5 definitions were applicable. This continued to grow. At the 190th phrase I could apply all 7 definitions and so pursued this for the first 300 phrases, then seeing this as saturation with the rest of the data for this theme following the same pattern. From these I chose 61 to use as summarizing examples.

Applying the definitions that link to each phrase revealed greatest emphasis on wellbeing definitions 3 (links with work culture or context) and 5 (life satisfaction, worthwhile, happiness, anxiety). The least recorded is on definition 4 ('shared mission'). This can be shown as –

1. Organic 36
2. Feelings 36
3. **Culture or context** **46**
4. **'Shared mission'** **17**
5. **Life satisfaction** **47**
6. Relationships 35
7. At home with yourself 31

This gives further clarity to the real wellbeing issues on which HCPs reflect which I will now explore further and argue their significance. By drawing together the themes from this analysis and applying the wellbeing definition model, the rest of my thesis will show the implication of this broader understanding of wellbeing and then, exploring the process, will argue for the value of their development of a reflective process to nurture this.

Developing 'wellbeing' outcomes, linking the themes

The thematic data analysis reveals in two ways how the HCPs reflections are consistent with a broader definition of wellbeing than only the institutional 'health' model. The first 6 themes demonstrate the issues on which they

reflect – professional concerns, making the human connection between themselves and with their patients, issues with patients and relatives, valuing the space to reflect together and with the desire for shared team support. These are consistent with the 'multi-layered, whole person in relation to their community and context' as a developed interpretation of wellbeing.

Secondly, by applying the wellbeing definition tool I have also re-examined this against the literature and affirmed the presence of the seventh theme of wellbeing, which the HCPs demonstrate in their reflections, being consistent with wellbeing including the holistic, relational and contextual understanding. Examining their reflections in this way, they show that their wellbeing is measured on the level of 'shared mission' (definition 4) but with a low score meaning it is mentioned less often. This suggests *either* that it is experienced less often or of least value to them. Yet, the actual words used suggest its high importance. They describe the supportive benefit of working with people willing to pull together and who share the same agenda. From the wellbeing tool, definition 4 includes working with "someone with a shared mission" and spending "time with people and teams you enjoy being around at work" (Rath and Harter, 2010, p.29). Of the phrases re-coded those placed against this include, already quoted, examples such as "nice team who work off the same page"; "teamwork/nicely ticking over – wish more days like this"; "colleague asks if they can do anything to help" and "team keeping situation safe". This links with the data theme of the 'value of team and shared support', where they reflect on issues, already quoted, that relate to the value of working alongside, sharing experiences and workload. Coping in the face of challenge they show is easier with a good team around them, valuing cohesion and being able to trust the reliability of others. A heavy and demanding shift is made manageable with the support of a good team: "it's your colleagues that help you" (15th April 2014). They show the desire for a shared goal, as well as a sense of job satisfaction, their own visceral need to

contribute to providing care, making a worthwhile contribution, in this demanding culture. I argue then that this combined shows how important the relational and contextual aspects of wellbeing are to them in their work culture.

The HCPs also show that their wellbeing is measured on links with their work culture and context (3), and on their own satisfaction, happiness and anxiety (5). In the data these two measures, being mentioned more often, each reveal a higher score. This would mean *either* that they are being experienced *more* or else are of greater value. Once more the phrases reveal their intention. These include the mix of both low morale and feeling alone but celebrating when the day has gone well; valuing meal breaks and moments of humour; celebrating team work and patient improvement and looking for ways of delivering good practice with the desire to care for human need; valuing space to tell this story. In both senses then, whether the higher score means definitions 3 and 5 are experienced more or of greater value, the words and sentiment express their worth. The HCPs express that their wellbeing links with their work culture and context and on their own satisfaction, happiness and anxiety, thus a more holistic sense of wellbeing.

Numerically, the 'wellbeing' theme is greatest in value. Combining the highest and lowest scores from using the wellbeing definition tool reveals the HCPs measure of wellbeing links, in *their* context, with a wider holistic, relational and contextual understanding.

Developing wellbeing as also holistic, relational and contextual

Taking 3 phrases (from 61 used for examples), to which all 7 wellbeing tool definitions apply, I will further show how this research reveals HCPs' view of their wellbeing. These examples of definitions from the literature include 'multi-layered' and 'work culture' from anthropology, 'feelings' and

teamwork' from sociology and 'satisfaction' from national statistics. These each draw attention to human wellbeing.

"Looking for a forum to discuss concerns re colleagues' style/behaviour – withdrawn because difficult to discuss anything – portrays bad image of department" (12th July 2013). This data shows the multi-layered issues and reflections of this HCP relating both to themselves and their team. It clearly relates both to feelings and to the work culture. It connects with issues of team work, satisfaction, relationships and the place within this of the HCP.

"Some rubbish days because of being busy – low because we're low in staffing – snap at colleagues because they'll put up with it but they're tired" (21st August 2013). Once more, this reflection has several layers relating personally and to their team. The issues relate to the work environment, people's feelings, how they work together and lack of satisfaction. This also shows the insight of how this HCP places him/herself within this context.

"Sometimes feels like everyone's having a go but reflecting on it I see it was a hard day" (22nd August 2013). The layers of personal and professional issues, the job culture, the relationships, teamwork and the exhaustion of this HCP within this scene is also evident.

Here are real people who, given the space, talk about their experiences, reflect on their stories and share their insights. As has been indicated in reviewing the data again (2017), the regular shape of the RPW became evident, meaning the issues raised and often the order in which these issues were discussed. The four stage 'HELP wellbeing reflection' process produced these themes – firstly professional concerns, secondly the human connection, thirdly reflecting on valuing their colleagues and lastly celebrating the value of the space to reflect. This reveals the reflections of the whole person, in their relationships and in their context. In both their data, and in the shape of

their reflective process, the HCPs show that for them wellbeing is more than health, that it also relates to the whole person, in relation to others, and in their current context.

Linking the data and wider definitions of wellbeing in the literature, I want to draw attention to the ONS definition I have used. Their 4 measures noted are "life satisfaction", "feeling what one does in life is worthwhile", "happiness yesterday" and "anxiety yesterday" (ONS, 2014, pp.1,2) which relate to one's quality of life. They also include looking back, reflecting on one's feelings. In their reflections the professional and human HCPs show that they too seek a quality of life. Connecting with a national data source, I invite those in healthcare to see wellbeing of HCPs as a national concern.

Thus far I have opened the window on the project data, the process of my thematic analysis. I give evidence of the emerging 7 themes, drawing the focus on wellbeing. I argue that, together, the data themes and the re-examined wellbeing theme are consistent with the broader definitions of wellbeing. Having shown the significance of this for HCPs, I will explore the process of using my HELP reflective model, arguing for its use towards developing reflective practice to nurture this new wellbeing understanding.

Chapter 4

The Furniture – the place of reflection and discovery

Developing his vision for 6th century monastic daily lives, St. Benedict's Rule includes his view of differing qualities of monks. He dislikes both those who spend their time "wandering" and those who live by "their own good pleasure" (Benedict, 1976, p.1). In his modern version of St. Benedict's vision, for today's world beyond the monastery, Jamison equates these to people searching or seeking but who are "self-regarding and self-referential" (Jamison, 2006, p.151). Journeying towards finding an inner sanctuary Jamison sees, from a Benedictine view, that it would be better to connect with a community and listen to others as a means of helping one's own growth (Jamison, 2006, p.151).

The final part of building the modern Benedictine sanctuary is deep inside, described as the furniture within (Jamison, 2006, p.138). It is the inner place of self-awareness and discovery, having a willingness to continue its development, to nurture further learning. This means it is the deep place within where awareness of God's presence can be known, where the on-going relationship can grow and be a source of nourishment.

The furniture for *this* project is also the inner place of self-awareness and discovery, the space for connecting with what has already been seen. I use this chapter to reflect on the process, adding to work on experiential learning, developing reflective practice with the HELP Wellbeing Reflection Cycle. I argue that I have added to the use of 'reflection-in-action' in developing the reflective culture in healthcare practice. (Chapter 5 will argue further for the reflective *space* within the HCPs community, to nurture the wider interpretation of wellbeing.)

I have explored, in Chapter 1, the nature of reflection and, in Chapter 2, the important place of research reflexivity. In addition, I made brief reference to one's own *professional* reflexivity meaning "thinking from within experiences", "able to stay with personal uncertainty" and "the self they find there" (Bolton, 2010, pp. 14,58). From that perspective, being reflective and reflexive means seeing the changes in oneself, examining what may be discerned more deeply. In this chapter, I share reflections *on* the practice, looking back to see what has happened. I apply the images of 'creating space', "empty handed" (Swift, 2009, p.175), and "welcoming guest" (Walton M., 2012, p.226) to this model and my own reflexive sense of the 'human' chaplain. I consider the significance of building and sharing the reflective space in the pastoral encounter as a source for learning. I also reflect *in* the practice meaning seeing day to day the net effect of the research now. (I have borrowed Schön's (1983) phrases 'reflection-on-action' and 'reflection-in-action' adjusting them to 'reflection on practice' and 'reflection in practice' to do this.) This will demonstrate change in practice that has resulted from my research. It also shows both the existing and potential contribution to an increasingly wider constituency, and a call for its further development.

Having identified a new *wider* understanding of wellbeing and demonstrated its presence in the data, I now use these two final chapters to draw together my contribution to knowledge and practice of a chaplain helping HCPs develop reflective practice to nurture this.

Reflecting on the process *"Do like the wellbeing cycle!" (17th June 2013)*

Building on work in experiential learning (Dewey, 1933; Kolb, 1984), seen in Chapter 1, my HELP Wellbeing Reflection Cycle develops the use of reflective practice in both a professional and personal way. I build on Kolb's view of the learning process that combines work development and personal integrity (Kolb, 1984, p.225). My reflective process also develops connections with the

whole person, linking "life situations" (Kolb, 1984, p.33). As an original model and using it for wellbeing, rather than for developing clinical practice, the HELP cycle advances the combination of work and self. The emphasis however, is on learning for personal and shared wellbeing in the work environment, through an increasing sense of self-awareness. It is a process, rather than testing new knowledge, that serves as a step for leaving the reflective space empowered with a greater sense of wellbeing.

This is a change in professional practice for HCPs and chaplains as co-reflectors. It is *not* supervision. While other forms of reflection are evident in certain parts of healthcare, my project works towards developing the practice further with groups of ward/unit HCPs in their own familiar team and specific environment. This works towards reflective practice as personal development tool through building space and as an evolving culture. It includes the increased trust in small familiar teams, wellbeing seen in relationship and support, giving voice to one another, learning from experience in oneself and together as a team.

My project further develops Kolb's (1984) work with the clarity and memorable nature of the 4-stage model, inviting self-awareness in the process of nurturing wellbeing through reflection-in-action. As detailed in the methodology (Chapter 2), by 3 months into data generation it was clear that the 5-stage reflective cycle had evolved into a simpler 4-stage process. Here each 'stage' often easily rolled into the next as the discussion in the RPW developed (Fig. 2 p.112). The words also at each stage evolved into simple memorable phrases. Over time it was often more of an aide memoire rather than a fixed stage process. With thanks to the HCP who called it the 'wellbeing cycle', I soon after developed the appropriate acronym 'HELP'. So, it became 'HELP Wellbeing Reflection Cycle'. As I have argued (also Chapter 1) if the culture of reflective practice in healthcare is to develop then the

reflective model needs to be simple, memorable and apposite for frequent use. Like the modern Benedictine inner sanctuary, it needs to be carried within. As I considered an acronym, it began with the 'highs and lows' of stage 1 that had evolved (May - July 2013) and then 'exploring' and 'learning' easily fell into place. The 'pondering' came instinctively from these famous reflections: "Mary treasured all these words and pondered them in her heart" (Luke 2.19 NRSV). The HELP acronym seemed apposite for a wellbeing reflective resource. Simple, clear and memorable, used frequently, it becomes a tool for life. The continued evolving use of this reflective cycle will be evident in both this and the following chapter.

Encouraging HCP groups self-facilitating

Encouraging the HCPs, in time, to self-facilitate their own reflective groups is also a contribution to reflective practice, healthcare and the chaplain's role. Two of the eight groups in this project have regularly been involved in self-facilitating, and subsequent to the project, other groups are developing this.

From the data, the first groups reflected as they began: "Cycle helpful, bit daunting but seeing how stages flow, seeing the deeper level" (17th January 2014). They also considered how to be facilitator and co-reflector in their own team context. They were mindful that the facilitator may not necessarily want to raise issues of their own, so from the data: "Discussed issues of taking it in turns – but if that person has issues, to hand over to someone else" (6th December 2013). They also saw the benefit of having space to "see deeper issues/how other people see it" (6th December 2013). This felt indicative of a team considering how to care for each other in this reflective space. Elsewhere, the facilitators saw the RPW as worthwhile "to take a moment" as a whole team (28th January 2014) and to use "these skills at other times, beyond the group" (26th November 2013). There were also reflections on the cycle becoming a natural tool with one facilitator reflecting how "in the past

we would have done something 'team building' but because of RPW felt easier, more natural to link with this" (11th June 2013).

Valuing space to talk

Returning to the data theme of 'the value of the reflective space to share', I consider further the HCPs expression of their own reflections *on* the process. They highlight four other key benefits to the RPW. It gives them space. They have an opportunity to talk together and share their stories as a team. It is a place to find ways of coping with stress and find deeper insights. They can explore both professional and personal issues.

Space was "to support each other" (15th April 2014) because they "need to find space to reflect and leave/learn from" (29th May 2013). It is "space to talk" because of the "risk otherwise of putting too much on yourself" (11th November 2013). They wanted "the pause in time to talk" (22nd July 2013) and of the RPW, "I could stay all day!" (14th May 2013). The HCPs express the need for designated reflective time because of the "need for the space when it's busy" and being "too busy to support gathering in any other space" (19th August 2013). There is the "value of making room…and find ways to cope" (22nd October 2013), and "to share feelings, good and bad" (26th November 2013). It is "a space to pour out your negatives" (3rd December 2013), and "to note the positives" (21st January 2014). It was clear too that as they became more familiar with the process, it became easier, valuing "establishing culture/comfortable talking with others" (6th December 2013). It seemed the RPW space was appreciated also as "Talking about it in here better that doing it out there" (3rd December 2013), and it was "nice to have a breather" (3rd January 2014).

Sharing and talking in the RPW meant there was "room to say things" (22nd October 2013), "being listened to" and "letting off steam" (13th November

2013). They said it was "interesting there's common feelings" (16th December 2013). The sense of need is clear: "Listening to other people you realize you're not alone" (13th December 2013). The RPW was a place to deal with stress, "not going out with things on your shoulders" (29th May 2013). While it "doesn't take it away but feel better" (30th April 2013), it "lets you re-evaluate your own situation" (4th December 2013). The RPWs gave "space to talk…and be energized to be professional again" (11th October 2013).

Developing this process, this journey of discovery, the HCPs at every stage reveal in the data the need to build this space to tell their own story. Commitment to high standards of professional practice, as shown in the data, is alongside their awareness of everyone as real human beings, as one who delivers and the other who receives the care. To nurture and sustain that level of care and commitment, strength to re-engage with the challenging work, the HCPs need to find the balance between professional distancing and making the human connection. Their reflections also expose the need for space to re-find their team connection, the invaluable nature of shared support, to re-connect with the shared goal. Using the reflective practice that this research project is developing, they found the space and strength to do this. It is indeed their work environment and their own visceral need to contribute to providing care, but with job satisfaction, that affects their own wellbeing. Within this reflective process their reflections, consistent with the broader definitions of wellbeing, gave them the opportunity to be both a healthcare professional and human.

'***Reflection-in-action***' (Schön, 1983)

My research project responds to and develops Rolfe's (2014) call to return to Schön's "reflection-in-action" (1983). As was identified in Chapter 1, this means that HCPs "reflect on-the-spot, in the here-and-now, and the products of their reflections are immediately put into practice in a continuous and

spontaneous interplay between thinking and doing, in which ideas are formulated, tested and revised" (Rolfe, 2014, p.1180). While Rolfe has the development of professional practice as the original intention, I have developed this in a reflective process to nurture the wider holistic, relational and contextual sense of wellbeing.

Reflecting in-the-moment explores the human experience as it is known, at this point in time, making initial processing possible. Combining the human and the professional, at this moment, it allows for reflecting with those involved, colleagues on-duty at the time and in this situation. It also provides the basis for later reflection once the initial thinking has given room to deal with today's challenge. The potential for spontaneity means issues are likely to be explored in their immediacy, relieving the pressure that a challenge may have brought.

It works towards reflective practice becoming a more visible feature of daily working life and practice. This makes it increasingly evident in the work culture and a source for self-discovery for those using my research model now. By becoming part of the culture, this may engender a more natural, less onerous practice of reflection for professional development also.

Challenges of the RPW

As has been indicated (Chapter 2), the challenges of RPW required flexibility in time and space with the risk of being unable to gather staff together in the face of work pressures. Here RPWs were cancelled at the last minute and an alternative date/time arranged. Certainly, on the odd occasion in the early stages there were times of staff reluctance to attend. This meant either there would a very small group (no less than 3) or no attendance at all. It could also mean, sometimes early on, the absence of any staff who *had* attended before, but as yet uncertain of the on-going value, even having expressed earlier

interest. Equally, it may have meant that on another day that week there would have been greater eagerness, for example, "Small group today…ward team not very enthused to attend – should I consider another day?" (Journal 8th July 2013).

However, as the project progressed, the reasons for a small group or cancellation was invariably work pressure. There were indications that familiarity with the RPW, or the presence of HCPs who had attended before and who encouraged their colleagues, increased enthusiasm. From my journal: "Ward/unit busy and insufficient staff for any to be relieved for RPW. Discussion with team leader – rather than 15.30 (suggests) could we try 17.00" (Journal 13th December 2013). This is why, as noted in Chapter 2, the need for my flexibility was exactly in line with the nature of their work context. There is also the sense that as the process became more familiar, its value felt, then so the enthusiasm grew.

The RPWs modelled both the benefit, as has been argued, and challenge of 'reflection-in-action' in the immediate work context of the HCP team. It can be planned according to the duty rota, mindful that circumstances may mean change. The RPW can also occur spontaneously anywhere within the ward/unit. As is known through learning a different language or musical instrument, practice and familiarity develop the skill. There were teams from the audit and pilot study who re-gained interest after an event or tentatively enquired after a colleague from another ward/unit is enthusiastic. Even when practice has fallen away, for whatever reason, interest remains and is re-ignited with need.

Evidence of the evolving nature of this reflective space will be seen later in this chapter. The following chapter is the herald to recognise the need to value, to give room, to build the space. Continuing to reflect on the process

of using reflection in this project, I will now explore the images that contributed to this development.

Listening - reflection on practice

Experiencing space for their own discoveries, HCPs have given *me* so much space to develop a deeper understanding of reflective practice, also learning from the richness of the pastoral encounters we shared in this research project. As images that have emerged in this project, I now explore 'creating this space', the 'hospitality' of this model and my own reflexive sense of the 'human' chaplain. I consider also the significance of building and sharing the reflective space in the pastoral encounter as a source for learning.

Listening, creating space

"Thank you, you've given me space to feel human again!" Response after reflective group (March 2013)

Amidst the constant and heavy workload for HCPs, 'space' in every sense for them is at a premium. Anecdotally this may mean a shortage of space for meal breaks or 'hours in the day' to fulfil all they strive to achieve in delivery of their high standard of care. Creating space then for reflection and self-care is a constant challenge.

As 21st century health, wholeness and wellbeing seem to be on everyone's shopping list, space is perhaps the very thing that people *do have* but without realising it. There is such a yearning for that space such that "health tourism" is a whole new phenomenon today, as people book into 'going to find a space.' It may be something like a spa, a retreat, a mindfulness course, an activity holiday or yoga classes (Smith and Puczko, 2017, p.20). "Space: the final frontier…" was the incentive and place for "voyages…to seek out" new discoveries, (The Phrase Finder, 2017), for the 1966 Star Trek Enterprise crew

and many subsequent sci-fi travellers. Yet the very space we seek today for refreshment and renewal is "closer to us than we are to ourselves" (Augustine, 1961, p.62). 'Space' as a key part of this research was evident from the very beginning when the first HCPs in my initial RPWs sank into their chairs, making it so palpably clear that they needed space to nurture their wellbeing.

Through this research project, I have developed a reflective model as a chaplain who empowers others to find space and so to nurture their wellbeing. I add to existing chaplaincy practice, although not heavily nuanced in the literature, the support of staff by developing this space in care of them. This is also a model for staff, personally and professionally, to consider for using themselves. It tests the idea of 'creating the space' by the way that the RPWs run, developing hospitality, dialogue, reflection, care for one another in the HCP team, for the nurture of a more holistic and relational sense of wellbeing of staff.

Emerging from my portfolio, combining the images of being "empty handed" (Swift, 2009, p.175), the "welcoming guest" and "mutual hospitality" (Walton M., 2012, p.226), have been significant in my reflections on this research project as 'building space'. I saw here the encounter as mutually beneficial, even if at the time the benefit may not always be entirely apparent. This mirrors the Emmaus Road encounter (Luke 24.13-32 NRSV) when arguably the two travelling disciples only really appreciate the effect of their encounter with the Risen Lord after He had gone. Here the reflections on my research project developed my sense of the 'encounter' as a hospitality and relational ministry, which are explored in the following sections of this chapter.

These images model the chaplain who celebrates the richness of humanity in the other person, willing to give time and space to hear their story. This is especially so when that story is challenging because where "there are no

answers, no quick exits to open, does not require the gifts of those whose hands are full" (Swift, 2009, p.175). Instead, it "calls for great patience, compassion and faithfulness to the value of the human being" before him/her and, as a "product of considerable preparation, maturity and deep personal self-knowledge" (Swift, 2009, p.175). It is someone skilled in creating space into which others tell their story and who feel accompanied in their story-telling as they develop their own reflective self-care skills: "For only when the chaplain's hands are empty will wounded people dare to offer their stories and allow their most intimate shards of doubt and hope to be handled with love and honoured with insight" (Swift, 2009, p.175).

Developing the 'empty hands' model, as I have reflected and fostered in practice, means creating space before, during and after the pastoral encounter. Taking time with reflective self-preparation, even if only briefly, before listening to someone in a pastoral encounter can create space within oneself, within one's own sense of self-awareness. This means being sufficiently able to put aside one's own story, making space to listen to the other person, becoming the 'empty hands' for them to fill with their story. The listener holds the broken treasure of someone's story in their hands while the teller finds the tools in order to be able to hold it themselves. As Swift (2009) implies, if one is burdened with one's own issues one cannot give honour and full attention to the other, unable to listen properly, insufficient emotional intelligence not to be overwhelmed by the challenge of what is being said. A chaplain who may have something even slightly onerous on their mind cannot give space to hold someone else's story.

This is further drawn out in the "welcoming guest" model where both the chaplain and the other person in the pastoral encounter share "mutual hospitality" (Walton M., 2012, p.226). The chaplain is "an interested guest, as a stranger in a strange land" but who equally is able "to welcome the

stranger...to host the strange" (Walton M., 2012, pp.228, 233). Making a gentle approach to any pastoral encounter, the listening chaplain carefully enters the other person's space, becoming alongside them as guest, but is also the host by beginning to create the space for the other person to feel able to tell their story. This connects with offering unconditional welcome and inclusion, meeting without judgement, with my willingness to be turned away because the hospitality is on the other person's terms. This means also the responsibility to be sensitive, even tentative towards creating the space.

Creating this space *within* the pastoral encounter involves being the "non-anxious presence" (Newell cited in Mowat et al, 2013, p.39), that "meets people where they are" (Mowat and Swinton, 2007, p.30). It means listening to the other person tell their story as, and if, they feel desirous to do so. Listening includes allowing space for silences and sometimes encouraging the speaker with gently prompting, for example by carefully asking why perhaps the issue has been raised or is on their mind today. It is the other person's agenda and at their pace, with the listener "being present while the other person works it out for him or herself" (Orchard cited in Swift, 2009, p.175). This is where it is "far more important that a person discovers what he needs rather than be given someone else's answers which may turn out to be a bad fit" (Long, 1990, p.34).

Focussed listening with occasional gentle prompting, inviting the other person to tell their story if they desire, helping the story-teller 'hear' what they have said, allowing space for silence, all involves reflection-in-action within the pastoral encounter. It means considering what is being said and not being said, seeing connections, and reflecting where, how, and if to prompt. To go beyond this would potentially be to re-fill the 'empty hands' of the listener. Giving advice, opinions or solutions turns the encounter to the listener's agenda and not the story-teller's, re-filling the hands and turning

attention away from the speaker. Having the 'empty hands' to be filled with the other's story means that the hands can only hold and show, not point or direct.

While perhaps more obviously exemplied in the pastoral encounter with the chaplain at the patient's bedside, I argue that together these images are also a valuable model when considering the shared reflective encounters of this research project. These skills as a chaplain, demonstrated in my practice, are akin to those in "ethnographic participation" (Emerson, Fretz and Shaw, 2011, p.2) and co-reflector in this project. So this is an ethnogprahic exploration into my practice in the context of the pastoral encounter reflecting with HCPs.

Creating space *after* the pastoral encounter involves reflection-on-action. As a result of this research project this is now the practice of chaplains and pastoral visitors of my team. In this project HCPs are reflecting 'in-action' in the midst of their own encounters with their patients. An additonal argument towards developing the reflective space of the pastoral encounter for HCPs will be further considered later in this chapter.

I argue that by combining in my practice these two models of "empty handed" (Swift, 2009, p.175), and "welcoming guest" (Walton M., 2012, p.226), the chaplain can create the space in the pastoral encounter. However, this challenges the view that the space merely occurs, for example Whorton's view of himself: "I do not create this space. If I try to manufacture it, nothing will be created. It is a place that I glimpse out of the corner of my eye" (Whorton, 2011, p.38). Equally, such a space has been seen as indicative of the chaplain's "vacuum identity" where they "fill a void rather than offering a well-defined service" (de Vries, Berlinger, and Cadge, 2008, p.25). Yet *I do* create this space, the "non-anxious presence" (Newell cited in Mowat et al, 2013, p.39), listening, shaping my response, reflecting and making

connections, the 'empty hands' that hold and show rather than point. Such a claim is supported by those who see 'space' created by listening:

> …the essence of what chaplains offer – generic spiritual listening – can be described as active non-judgemental listening that creates a 'dynamic holding space' which…the storyteller, can use to talk about the present and to revisit and reinterpret events from the past, and in so doing maintain their story or create new possibilities, even a new sense of hope, for the future (Kennedy and Stirling, 2013, pp. 62,63).

This is a vital space where wellbeing may be nurtured: "Understanding the link between wellbeing and the act of listening gives theoretical substance to the core work of chaplaincy" (Mowat et al, 2013, p.35). This is a place of nurture, with "spirituality as a way of naming absences and recognizing gaps in healthcare" with "the image of putting a rope around an area of deserted land in order to allow wildlife to develop and flourish" (Swinton and Pattison, 2010, pp.226, 234). This is a space for discovery, development and change.

Listening, creating space – a "blurred encounter" *(Reeder and Baker, 2009)*

The space I create for reflection in the RPWs, and in any form of pastoral encounter, are each a "blurred encounter" (Reeder and Baker, 2009). As such they are also the "Third Space...the space that exists in the middle of any set of binary opposites", a space which "is constantly evolving and changing" (Reeder and Baker, 2009, pp.4, 5). These are "blurred encounters to thresholds of transformation" (Reeder and Baker, 2009, p.219). Here, the

> …threshold represents the space of new insight and opportunity from which to engage in transforming and purposive action...never the end of the journey...the start of another journey into a new set of encounters (Reeder and Baker, 2009, p.220).

Therefore, I think my reflective 'created space' is an example of "a new theological space" that has been identified in 21st century social and public theology. As the chaplain and HCPs reflect, together they are the "blurred encounter" (Reeder and Baker, 2009) of their mixed professions, sharing the interface of their mixed perspectives and find a place for mutual learning. The contribution to public theology made by these encounters is addressed in Chapter 5.

Learning from each other, each person within this space is *also* the 'blurred encounter'. The HCPs demonstrate valuing this space to re-engage with being both professional and human. Equally, there can be no separation from 'me' and being a priest/chaplain, in this relational ministry demonstrating the 'vulnerable human chaplain' who is the 'reflective companion' with HCPs. I argue that is a valuable contribution to chaplaincy healthcare practice.

Listening, creating space – hospitality and space for change

The 'blurred encounter' of the space for reflection, and the shared presence of chaplain and HCPs there, is also a space for change. The model of chaplaincy I am testing has evolved from my 'explorer-archaeologist-safari guide' (Chapter 1), now developing into 'creating space' by being "empty handed" (Swift, 2009, p.175), and "welcoming guest" (Walton M., 2012, p.226). I wanted to know if we, chaplain and HCPs, can share particular professional skills and learn from each other. As chaplain, as one "who know[s] what it means to inhabit uncertainty and change" (Swift, 2009, p.169), this is a person whose own journey and profession involves a relational ministry. It is one who is alongside and who identifies transformation. Sharing the opportunity for learning and change, this invites the possibility of developing oneself and others in the reflective space.

I am grateful for supervision (April 2013) where I was reminded of the presence of hospitality in the "welcoming guest" and "mutual hospitality" (Walton M., 2012, p.226) that I have explored. This connects with the listening nature of chaplaincy, as in any context "being listened to and telling our story is in itself therapeutic and life affirming" (Mowat et al, 2013, p.35), where the listener holds the story allowing the teller to make their discoveries. Moreover, "Listening is a foot washing ministry…to do with attitudes…availability, compassion, belief in people – knowing from our own experience what being heard can do for us" (Long, 1990, p.35). Here, I reflect that the priority is given to the other, but if this were to be mutual both would be heard and loved. Equally, listening has been described in terms of "gift, hospitality and healing" (Long, 1990, p.35). This is "mutual rather than one-way, for the listener in giving also receives – the trust, confidence and vulnerability of the one who turns to him" (Long, 1990, p.36). From my own professional experience and reflections, I know this sense of privilege of being told someone's story and therefore 'gifted' with material for my own reflections and learning. It is a shared place of hospitality and change.

Hospitality, as a term first recognized in the 14th century (Merriam-Webster Dictionary, 2017) describing feeding and housing people journeying on the road, is the source from which hospital and hospice originate. The philosopher Jacques Derrida declares "an act of hospitality can only be poetic" (Derrida and Dufourmantelle, 2000, p.2), describing this complex meeting place of strangers. He states:

> …absolute hospitality requires that I open up my home and that I give not only to the foreigner…but to the absolute, unknown, anonymous other…and that I *give place* to them, that I let them come, that I let them arrive, and take place in the place I offer them, without asking of

> them either reciprocity…or even their names (Derrida and Dufourmantelle, 2000, p.25).

Derrida sees hospitality as a paradox because it makes the host the unwelcome stranger. This connects with reflections on "mutual hospitality" (Walton M., 2012, p.226) where, in the pastoral encounter and the reflective space, the chaplain paradoxically both fills the gaps and creates the space in that tentative step as both host and guest.

As part of his own inner life and journeying Henri Nouwen**,** Dutch theologian and priest, saw creating space as making room for others, sharing humanity, and where both may be changed. Moving from "hostility into hospitality" (Nouwen, 1998, p.43), both "guest and host can reveal their most precious gifts and bring new life to each other" (Nouwen, 1998, p.45). This is "a fundamental attitude towards our fellow human beings" (Nouwen, 1998, p.45). This meeting or encounter, this hospitality, is "the creation of a free space where the stranger can enter and become a friend…Hospitality is not to change people, but to offer them space where change can take place" (Nouwen, 1998, p.49). This is a place of "mutual hospitality" (Walton M., 2012, p.226) and the potential of mutual learning. This is "friendly emptiness where strangers can enter and discover themselves as created free...free also to leave and follow their own vocations" (Nouwen, 1998, p.49).

Creating space means letting go of the busy life, letting go of the fear of space (Nouwen, 1998, p.50), if only briefly, and, like being "empty handed" (Swift, 2009, p.175), means there is room for something new to be discovered. In their context, of teaching in adult learning, Groen and Kawalilak (2016) consider how giving room for one another, and hearing one another's story can be a place of real transformation:

> Focused on intentionally slowing down the pace and interrupting the scurry of activity, we aim to create spaces in support of the emergence of opportunities for reflection, dialogue, and a substantial conversation about how we might change things around us (Groen and Kawalilak, 2016, p.62).

In a sense, this project builds space to 'slow down the pace' for HCPs, and room to reflect on their unremitting work. Building space for reflection to nurture wellbeing, in this project, has included room to notice the human connection between HCPs and their patients. Reflecting on the "profound intimacy" between nurse and patient, Swinton and Vanderpot observe:

> It is the space between that matters. The space between is the place of meeting; it is a space that is not created by distance, but by a mutual movement towards one another in an attempt to create space for care that values, respects, and offers hospitality towards both participants (Swinton and Vanderpot, 2017, p.215).

It is that very space, that professional relationship, on which this research project builds. This project honours that working 'space' and offers HCPs the opportunity to build from it, to develop another space where reflection on the former can help them rejuvenate. It invites them to explore the new space as a source for learning, and from it help them nurture their own wider sense of wellbeing to be also holistic, relational and contextual.

This builds on an encounter being an offer of hospitality to one another for mutual discovery and change. Perhaps this is a messy place, but it is human. It is a space where all are welcome, each story valid and valued, the richness of shared humanity celebrated, with the willingness to be changed by the experience. This project moves towards developing the reflective space,

creating a hospitable transformation space as an encounter where wellbeing may be nurtured.

Listening, creating the reflective space in the pastoral encounter

The word 'encounter' originates from terms to describe meeting in conflict, the unexpected and the adversarial (Merriam-Webster Dictionary, 2017). Contextually, as a chaplain, the 'chance encounter' is the unexpected engagement with a patient, a visitor or member of staff. Anecdotally, I reflect that any encounter is always a pastoral encounter because the work of the chaplain is a "ministry of care" (Cobb, 2005, p.42). From September 2016, I suggested we call our department's training volunteer course 'Creating Space: The Pastoral Encounter' in order to describe my sense of the pastoral encounter as space for reflection. It also demonstrates how my research has impacted on the culture of our team, both chaplains and trained pastoral visitor volunteers. (This is further explored later in this chapter.) Our images of the listener being a 'vomit bowl' or 'garbage bins' (Dept PSC, 2016) are perhaps less attractive, yet they come from significant reflections on pastoral encounters from within our team. These images describe the holding of something that needs to be expressed, got out, removed and looked over. They indicate something of the processing, the space that is 'reflective practice' and also a sense of liberation in the story teller.

In chaplaincy, regardless of the context, the listening presence *is* the pastoral encounter, with the pastoral care as the focussed listening, and spiritual care as this space to help the story teller to listen to themselves. The modern Benedictine sanctuary model encourages a deeper relationship with God through listening to oneself, to others and to God, and all this within the stability of one's community (Jamison, 2006). For me, the reflective space for nurturing wellbeing is precisely that listening space, for discovery, shared learning and nourishment. This is my professional practice, to listen to others

and help them listen to themselves, so it remains my motivation to empower others to discover this for themselves and their colleagues.

The reflective space that is a pastoral encounter with chaplain and HCPs combines practical theology's roots in theological reflection and healthcare's foundation of reflective practice as a method of education. It returns reflection to deeply embrace the 'experience' that Dewey (1933, 1938) advocated and the "reflection-in-action" that Schön (1983) saw as the source of knowledge. It returns reflection to the 'story of the heart' that is key to theological reflection (Graham et al, 2005).

Reflective space in the pastoral encounter as a source for learning

Through this research project, I have grown to see more widely the pastoral encounter as a source of learning through reflective practice. The value of the chaplain reflecting on their own pastoral practice is familiar in their professional development (Kelly, 2010; Kelly and Paterson, 2013). The pastoral encounter is a tool for learning because "pastoral practice not reflected upon is practice that only partially fulfils its potential" (Kelly, 2010, p.48). Developing reflection using the HELP model in my chaplaincy practice of reflection in the team of chaplains and pastoral visitors, I have seen how the pastoral encounter is repeatedly the source of on-going learning and in this mixed group. Creating space and growing skills in the reflective group, who daily develop their practice through reflection, consider how today will make them a better pastoral carer tomorrow. Each of today's pastoral encounters informs and develops practice for tomorrow. I came to reflect on this in the context of the research project meaning considering the reflective space of the RPWs with HCPs who ask themselves a similar question at stage 4 of the HELP Wellbeing reflective cycle. What have I gained from today and this reflective space? While I argue that the reflective space *is* a pastoral encounter with chaplain and HCPs, it is space for the HCPs to reflect on their

own encounters, seeing both the experiences and themselves as a source for learning. This I argue contributes to their wider sense of wellbeing as also holistic, relational and contextual.

With the reflective space as both chaplain-facilitated *and* HCPs own self-sustainable regular tool, this develops through their relationship, not simply self as a functional tool but self as relational and organic. Chaplains' support of staff in terms of education in the provision of spiritual care continues to develop (Timmins and McSherry, 2012; Kennedy and Stirling, 2013). Yet my deeper interest is in the pastoral relationship with them, and to support and empower HCPs actual care for themselves.

Creating space – the human chaplain

The congruent, genuine, organic chaplain who develops a professional relationship with HCPs is, I argue, evident in my practice and tested out in the reflective space of this project. This involves 'me' creating space as the 'human' chaplain. This sense of shared humanity, in relational work with HCPs through openness and vulnerability, has subsequently developed my growing understanding of the 'pastoral encounter'.

From the first encounter with the HCP in 2010 who asked me to help the morale of his team, I became more aware of creating the space with the relationship with wards/units. My regular visible presence means increased staff contact, and the open way in which we relate. Healthcare staff call me by name in the corridor, some of whom I have never met. My style is open, sociable, often through the staff's experience of our chance encounter, easy chatting and willingly paying attention to them. By being easy and open with people often a rapport is made, like friends, interested in them as people. There are also, over time, their experiences of working with me alongside their patients and visitors. Although I wear a clerical collar, my faith is not the

first tool out of my kitbag. Time working together, developing a professional relationship, I experience as building that relational trust.

In my RPWs, there is open space for discussion and the agenda is theirs, prompted only by stages of the reflective cycle, in a relaxed atmosphere and easy free use of language. I identify the space and create it by a presence of accessibility, openness and hospitality, sharing stories and experiences. This is also in humility in the true sense of self-awareness, recognizing and identifying the richness of our shared humanity. This is my practice, reflecting together, developing relationships and growing confidence and trust, as a route to personal and team wellbeing. It includes *encouraging* vulnerability by being willing to show it and sharing it, making the human connection and sharing companionship.

I am a chaplain who is carer for that space, the one who creates it and notices its presence – and the one who identifies transformation there. I am the 'welcoming guest', sharing the space, and arrive there relationally and by showing vulnerability. I am the human chaplain. I recall being described by a member of staff as 'a real presence in this hospital' (Journal 12th February 2013). In my professional practice a pastoral encounter is never about my story but instead to hear and welcome the story-teller and their story. However, in my RPW for HCPs, I believe that creating the hospitable space is where anyone's story can be told, including modelling with care and sensitivity occasional relevant contributions of 'me' alongside the story-telling of others. This may add encouragement for others to contribute in this open, welcome space, in this dialogue:

> My RPW often include recognizing professional boundaries but reflecting on how it feels as the patient's loved one and so making links with vulnerability and fear for one's own, which recently

connected with describing, anonymously, a pastoral encounter of mine, and developed the discussion into further issues of professional distancing versus being human (Journal 8th July 2013).

Creating space – shared humanity and pastoral care

I want to consider further the *shared* humanity and pastoral nature of the reflective space, continuing to argue for this connection in chaplaincy's support of HCPs. In the context of the healthcare chaplain, Mark Cobb offers an inspiring and tangible understanding of the definition of 'pastoral' that feels celebratory of the richness and privilege of a ministry in the environment of acute human experience:

> Pastoral care is the practical embodiment of belief in humanity within a theological framework that is critically sensitive to context and disciplined in its response. As a creative art, pastoral care goes beyond applied technique and has the potential for being nourishing, inspiring and transformational (Cobb, 2005, p.43).

This project re-affirms the pastoral in this way, as open and accompanying, without imposition or expectation, save for empowering the other person. In the context of lived human experience, 'pastoral' is the reason for gathering, the accompanying and sharing stories, with a "belief in humanity" (Cobb, 2005, p.43), and a desire for "human flourishing" (Graham, 2011, p.233). Listening to and sharing stories, our "human life is storied existence" (Swinton, 2015, p.300), so a source of a wider sense of wellbeing as also holistic, relational and contextual wellbeing.

Seeing the 'pastoral' within 'practical' theology is "distinguished by its focus on the theory and practice of the human life-cycle" (Graham, 2009, p.153), making 'pastoral' an engagement with human reality. Criticism of the

traditional, shepherd image of pastoral care as having an imposed, however gentle, dependency implication, draws McClure (2012) to highlight an alternative: "As a consequence, some contemporary care providers reject this image in favour of a model in which both caregiver and care-receiver journey together on an agenda set by the recipient of care" (p.277). Further, this is "an interdependent and deeply entwined human condition" (McClure, 2012, p.277). Therefore, here, 'pastoral' can be seen as a place for shared discoveries. Moreover, as a professional practice, the contextual and individual, creative and transformative nature of pastoral care means it cannot be simply work that is practised. It evolves *through* practice, reflection and development, allowing each pastoral encounter to be a source of learning. This again is because *without* reflecting on the pastoral encounter the "potential" (Kelly, 2010, p.48) to learn from it is lost.

In her ministry, Doehring (2015) "discovered that pastoral care was not just a matter of listening to those unfolding stories…it was also about co-creating meanings" and developing this in an environment of trust (Doehring, 2015, pp. xiv,xv). She found that, "Relational trust opens up a space for co-creating meanings that make emotional and spiritual sense within the narrative context of personal and communal life" (Doehring, 2015, p.xv). Her pastoral care model of "listening, assessing and co-creating", while focussed on being offered to people of faith, is in "caregiving relationships" (Doehring, 2015, p.37). It is based on listening to stories, becoming aware of context and the values of the story teller, and making sense together of the way ahead.

This project similarly embraces both the care and the creative nature of the pastoral encounter where, in my research, HCPs and the chaplain grow in relationship and mutual trust. Here, the pastoral encounter creates a space for listening. It is a meeting place, where each person shares the space, alongside and accompanying one another. Building space to use reflection

on human experience, in the context of HCPs, is a place for encounter and change. This project argues that while the chaplain brings the repository of theology as a resource, in this context the use of reflective practice for inner discovery, it is without expectation that the other in the pastoral encounter has, or desires to have, any faith themselves. This is true of the chaplain's role at the patient's bedside and also here in the reflective group with HCPs.

As argued in Chapter 3 in the data analysis, when I saw the 'human connection' theme in a reflective session I looked back knowing I had seen it before. Through the on-going reflexivity of this project, I have grown in my understanding of its greater significance. Linking the humanity of the HCP, the patient and the chaplain, reveals the richness of these connections in developing a reflective praxis that nurtures a new wider understanding of wellbeing in healthcare. As a chaplain creating space for HCPs to talk and listen to each other, it is the visible reality and value of shared humanity, connecting and exploring human experience, being reflective companions, nurturing wellbeing as also holistic, relational and contextual. Together, they discover their own sense of incarnational wellbeing. For the chaplain the word 'incarnational' will connect with the sense of the divine presence deep within human experience. However, for both the chaplain and HCP 'incarnational' is also corporeal, the sense of shared humanity. This is also the shared humanity revealed in the data linking HCPs and their patients.

This returns to the connection with listening to the reality of the human situation in the pastoral encounter (Osmer, 2008) seeing it as a place of change. This returns as well to seeing the human story and personal nature of 'living human documents' as a source of reflection and learning (Graham, 2009). It mirrors also the sense of the listener in the pastoral encounter who is deeply changed by the experience (Stoddart, 2014). It is this shared space of human vulnerability that is the forum for moving towards reflective

practice nurturing a holistic, relational and contextual wellbeing. I now consider how this looks day by day, reflecting in practice on the effect of this research project, in support of arguing for its on-going and wider development.

Looking Now – reflection in practice - day to day

"Are you still doing your reflective stuff?" Healthcare professional, hospital corridor (March 2016)

The three years that have lapsed, following the data generation (April 2013 – April 2014), have given space and opportunity to observe any cultural shift or influence affected by my research. This means looking for change, or development in practice, either in the chaplaincy team or in HCPs within the location of the research project. These observations can be identified in the following themes of teaching, of staff support, working with new reflective teams and the effect on our chaplaincy department.

Teaching

From very early on in my research, I was invited either by the local university or professional development tutors to teach reflective practice to a variety of HCPs, going from NVQ to Diploma, Degree and Master's levels. Initially, I taught an introduction to reflective practice combined with holistic care of the patient and one's self (to healthcare assistants) and this developed in several areas combining reflective practice with other subjects for registered HCPs. These included reflection as part of exploring spirituality and religion, self-awareness and wellbeing themes, and a variety of 'end of life' and bereavement training.

As a result of my doctoral study programme, from 2010, I have offered two distinct study days on several occasions for diocesan and local clergy (from 2011). The first was 'Practical Theology in the Acute Hospital Context' which explores the reality of healthcare ministry, to aid reflection on their pastoral and spiritual care (parish or elsewhere), and offer a fresh understanding of our shared ministries in the light of today's study of practical theology. This evolved into, in addition, a half day for curates introducing them to hospital visiting, the profession of healthcare chaplaincy and the distinction between pastoral care as a parish priest and as a chaplain.

The invitation to support one of the healthcare professions, now required to show evidence of using reflective practice as part of their registration re-validation, has been described (Chapter 1). For them I designed a study session with a re-familiarization with reflective practice and the use of my HELP reflective cycle and group support. Other teaching has included medical students, initially an annual session as a special studies unit exploring spirituality which I developed into the study of spirituality, holistic care and reflection.

Staff support

Regularly seeing staff one-to-one for reflection and also facilitating staff teams' reflection has provided two distinct and regular means of staff support as a result of my research project. The reflective practice research has been both the means and the tool by which this has developed. This has been through growing awareness across my data source and across the hospital either directly from the teams/units involved or from HCP or different levels of management. The actual practice of reflection using my 'HELP Wellbeing Reflection Cycle' has become my usual reflection tool, either literally or as an aide memoire, and grown to be used in several wards/units in their own way

and timing pattern or else invite me to attend in the event of a particular subject need or after an event or crisis.

There is a distinct culture now, a presence of either a regular pattern of reflective practice sessions or single event-based sessions using my reflective cycle as a result of my research. Of the eight teams involved in my research project, seven of them use my reflective method in one form or another. They are identified here by the group letter used within my data.

Group A

This ward/unit is staffed in two teams both of whom contributed to my data. Both these staff groups use my reflection in different ways now. One of them has an opportunity most days to gather towards the end of the afternoon in an office within the ward/unit. As people come and go so one of the HCPs informally encourages some reflection on the day or recent issues. At their invitation, I share in this around every 6 to 8 weeks to facilitate. The other half of this staff team arrange with me to visit during an afternoon approximately every 4 to 6 weeks when as many staff as can be released gather in a training room within the unit to reflect with me. Both small groups number between 4 to 6 staff gathered at any one time.

Group B

This ward/unit I see only at their invitation to provide 1:1 staff support or after an event where they seek single session reflective support.

Group C

This team gather to reflect, using my model, each week early on one particular morning as they prepare for their day. They average 7 or 8 in number and rotate the facilitating role, agreeing that the facilitator does not necessarily raise issues of their own but encourages the others to do so. On

an *ad hoc* basis I 'drop by' occasionally or else attend at the invitation of one of the team. Several of this team have, subsequent to their involvement in my research, asked me for 1:1 support on both personal and professional issues.

Group D

This team's use of reflective practice has developed from their regular use of my 'HELP' reflective cycle. They meet at the end of the day to reflect on the day's work, facilitated by one of 2 members of the team with particular interest in reflective practice. Once a week they meet at a time to involve their whole team to reflect together more widely. At their invitation I meet the whole team, or as many as choose to attend for a reflective session approximately every 6 to 8 weeks in a corner office in their unit. This team has used my 'HELP Well-being Cycle' in their own team development training and other study days. This team have also, using my model, created material as evidence to show how they use reflective practice in their team and to encourage other HCPs at a professional conference.

Group E

This ward/unit seeks my support after a crisis, one-off events, or after a stressful period of time. We gather in their staff room at an arranged time and as many attend as choose, usually 4 to 6 HCPs. At other times, in their own pattern they gather as desired and any reflection is facilitated by one particular member of the team.

Group F

This ward/unit invites me to facilitate reflection both after a crisis, one-off event, and irregularly inviting me to gather staff after a period of stress. We meet in the unit manager's office or a meeting room adjacent to the unit.

Group G

This team/unit have a monthly study session, an allocated period during part of a day for various forms of professional updating. In varying patterns, reflective practice sessions are arranged, for any of this team who wish to attend, during this time. These are usually facilitated by me but have on occasion been led by a member of the team. From both this team's contribution to the research data, and this on-going connection, several of the team seek me out for 1:1 reflection on personal and professional matters, and I am involved in various other means of staff support there.

Group H

This ward/unit, by the very nature of the patients for whom they care, experience several kinds of patient-based challenges. They were invited by senior management to consider whether making use of my reflective practice research and available sessions may be of use. These sessions have been both frequent and regular, as well as varied and spasmodic, often based on the unit's need.

Beyond the first teams

The wider response to my professional use of reflective practice with HCPs, and the specific use of the HELP Wellbeing Reflection Cycle, has gone well beyond the initial teams. Distinct examples, over these three years, reveal the image of the chaplain as 'reflective companion'. These include a team who following a very stressful period of time that also involved staff bereavement and another team after a series of challenging events in both clinical practice and for team members invited me to meet with them on several occasions. Other teams have invited me after so-called 'never' events, or distinct individual or team crisis, or a distressing albeit routine occurrence. These have been either urgent calls to set up a reflective session now today or else

to plan one or several in advance. Several ward/unit teams, hearing of my research and deciding that their morale could be helped with reflection have asked me to help them use it. We have met in teaching rooms, in a variety of offices, round desks, tea-trollies, clinical rooms, side rooms and ward sluices, to name but a few. Individual staff have asked if they may use the 'HELP Wellbeing Reflection Cycle' elsewhere in their non-work occupations and groups and/or to take it to other professional groups.

From this research the role and my chaplaincy team's link with occupational health has developed in two ways. From the early stage of the data generation the now operational group for 'staff health and well-being' were supportive of my project seeing this as part of their portfolio. Further, the chaplains are seen as the 'crisis team' in terms of immediate staff support on the ground, being available 24 hours a day, offering reflective sessions for wards/units even on an on-call basis. This research has made this both possible and visible.

2016-17 has seen invitations to set up RPWs for non-professional and non-clinical healthcare employees of which there are now several on-going.

Chaplaincy Team

Since starting my chaplaincy ministry in this department in 2009, my research project (2010 – 2017) has been the source of the cultural shift making reflective practice, with my HELP Reflection for Wellbeing, the familiar daily language and method of reflection. It is the source of the department's experience of discovery and commitment to the shared journey of learning.

It is used daily with pastoral visitor volunteers and chaplains in our department at the end of the volunteers' morning visits. This is facilitated by a chaplain, or one of the more experienced volunteers as their ministry develops, but really it is reflection in dialogue following this model. As has

been outlined, it is the method used regularly with HCPs reflective groups and in urgent reflective gatherings, and now in a small number of non-clinical staff across the location of my research project. The way in which our chaplaincy team offers reflective practice across the hospital continues to develop and this research project, using my HELP reflective model, is the source and model. It is the reflective tool of my department's chaplaincy practice.

In the department's twice yearly pastoral visitors' training, as has been mentioned now called 'Creating Space: The Pastoral Encounter', the central focus is reflecting on every aspect of the pastoral encounter. It introduces new volunteers in their pre-practice training to reflective practice as a means of learning and self-development. As the course continues to thrive and develop, regularly reviewed based on constant discoveries, reflective practice is the central tool for learning and the central feature as the course gains attraction in local parishes and in the local dioceses.

Taking responsibility to organize the annual Southwest Chaplaincy Conference (May 2017) my colleagues and I wanted to showcase the way in which my research material has radically changed the practice of our department and the way in which this has continued to develop and contribute to, what we now call, our journey of shared discoveries. This was offered encouraging local colleagues to find their own way of reflecting together, with our support if desired. Prior to this, a local chaplaincy team had invited me to provide a study day for precisely this.

This research project provides potential for these further developments in a wider constituency both in and beyond healthcare. Thus far in this chapter I have reflected on the process using my reflective model and the HCPs response to it as a much valued space to talk personally, professionally and as a team. I have argued that this project has further developed 'reflection-in-

action' as spontaneous reflective practice in the local community of the HCP team. I have explored the motifs of 'creating space', and the "empty handed" nature (Swift, 2009, p.175), of the "welcoming guest" (Walton M., 2012, p.226), of the human chaplain. These are modelled in my chaplaincy practice and emerging from this project. The developing effect of this research in healthcare and in chaplaincy I have also described. I will now draw together this thesis, concluding to what extent my research question is answered, affirming that it is desirable and possible, and further argue my contribution to knowledge and practice.

Chapter 5

'Building space, for listening, by listening'

This thesis imagery of sanctuary mirrors the purpose and work of this project, meaning building a particular space. The modern Benedictine model developed by Jamison (2006) builds the space, within oneself, of an inner sanctuary in order to find a deepening relationship with God. This involves listening to others, to oneself and to God. Key to this is to be congruent, to be true to oneself, humility in the real sense of self awareness, vulnerable and truthful about oneself, genuinely being oneself. It also involves living in community, being in conversation with one another. This research project builds space, developing reflective practice for nurturing wellbeing for HCPs, empowered to listen to one another and their own contextual professional and personal story. It mirrors the community listening in the 21st century Benedictine model. Once built the modern Benedictine space needs to be used and nurtured if it is to survive and continue to grow in its contribution to knowledge and practice. Before drawing conclusions, I consider now how the 'building space', for listening by listening, of the reflective practice of this project can be used and nurtured – if it is to survive and continue to grow in its contribution to knowledge and practice.

My research question asks: can a chaplain help HCPs develop reflective practice for wellbeing for themselves and their team? To what extent is this desirable and possible? I argue one can be affirmative in answer to both these questions. Motivated by being invited to help low staff morale and testing my ontological and epistemological position, I have challenged the healthcare understanding of wellbeing from 'health' to a new understanding of 'holistic, relational and contextual', and moved towards developing a reflective praxis that nurtures this new understanding. I develop the practice

of chaplains in reflecting together with HCPs. Drawing together my contribution to knowledge and practice, I point towards an essential and exciting future for chaplains and HCPs in nurturing wellbeing in the midst of the acute and deepening challenge of working in today's NHS. Seeing beyond this research project there is potential for this in a wider constituency both within *and* beyond healthcare.

In arguing this position, I now re-visit the use of reflective practice in healthcare, to identify further what is not evident in existing practice. I argue that my research is moving towards a response to this and for its further development. I will identify the value of reflecting in the ward/unit context and use the modern Benedictine spirituality model to support this as 'conversation in community'. I will argue for the holistic, relational and contextual priest/chaplain as a contributor to public theology in today's healthcare. I will then draw conclusions to this thesis and point to its further development.

Listening in the large community

Reflective practice for professional development and as a facilitated tool in healthcare were described in Chapter 1, acknowledging in some a suggestion of the personal value. Re-visiting these examples I will argue that my project moves towards developing them further and makes a particular contribution.

From the examples described, the human contribution to medical procedure safety is addressed by safety provider Terema (2011) using team briefing and de-briefing, while health educator Oelofsen (2012b) urges reflection as a source of learning across the NHS institution. The NMC (2016), the nursing/midwifery authority, now require evidence of reflective practice for professional development for registration re-validation, while Kelly and Paterson (2013) provide a supervision tool for chaplaincy groups. I argue that

this project develops more significantly the human connection between HCPs themselves and their patients, moves towards developing reflective practice within the healthcare culture and is not supervision. Moreover, it develops the reflective culture within the context of the ward/unit, listening in community in their smaller local immediate context. I especially want to highlight the contrast between the large community Schwartz Centre Rounds and my small community RPWs using my HELP Reflection for Wellbeing cycle.

As described in Chapter 1 the Schwartz Rounds are a sponsored gathering for support of multidisciplinary staff, reflection on a large scale. They rely on a panel of 3 or 4 staff giving a verbatim preparation based on the agreed theme, in a gathering of staff in a large forum away from their work place. It is an important and visible response in support of staff, but attendance is "relatively small" in a large hospital (Macmillan, 2017, p.6). It does encourage a feeling of being part of the larger institutional community, but it does not 'create space' for individuals or their familiar team to develop reflective practice in their own context. Requiring a great deal of planning and individual 'Round' preparation contrasts with developing the spontaneous 'reflection-in-action' culture in the immediate local context. As has been seen in the motivation for this research and in the data, HCPs are looking for space to have their voice heard, team connection improved, the invaluable nature of shared support, to re-connect with the shared goal.

These forms of larger reflective gatherings or calls for using reflection or reflective-style training are valuable programmes and supported by large and well-known organisations. Nevertheless, they are programmes of training or techniques, and remain a product requiring attendance away from the workplace. Moreover, they focus on the larger community of the hospital rather than the local issues of the individual ward/unit team. Neither do they

nurture that team or individuals in their context to build space to tell their own story in the immediacy of their own team. In this project the focus is on empowering HCPs as a resource for self-care, to nurture holistic and relational wellbeing in their own small community and context.

Listening in the small community

The developing process of reflective practice of this project is the contextual, human experience of the pastoral encounter with chaplain and HCPs, using the simple HELP reflection model in small reflective practice groups. Here the HCPs tell their own story, listen and story-tell in their own team, dealing with their own context. Examples from the data have shown that the HCPs reflected on professional issues, making the human connection, the value of team support and the space to reflect together, needing a shared goal and to feel that they make a contribution. These themes, consistent with the holistic, relational and contextual understanding of wellbeing, have emerged from conversation in a reflective space, from within the community of the respective ward/unit. As the data has shown these issues can emerge from a variety of reasons such as a series of distressing events, concerns of staffing levels or a challenging number of patients, and the HCPs demonstrate the value of having space to talk over these issues. The reflective space is contextual, holistic and relational. It is 'conversation in community'.

Conversation in community

Returning to the listening and journeying Benedictine monastic model (Jamison 2006) to explore this further, I argue the value of this significant paradigm for talking and learning together in the context of the shared goal and shared space. As has been described, the Benedictine inner sanctuary is an internal build of space, one's own sanctuary for self-awareness and to find one's own deepest discovery. The log cabin imagery of this sanctuary used to describe this thesis has included building the walls meaning listening to others, the ladder as the steps or process of discovery, the windows to let the

light of one's community help that learning, as well as the inner furniture as the reflexive deeper learning. The Benedictine vows (mentioned in Chapter 3) commit to obedience (listening to others and discerning how to respond), stability, and "a resolution to live with others" (Jamison, 2006, pp.76, 116). These responsibilities involve being in conversation, listening and speaking to one another, living and working together, relating to one another. This is analogous to the small community of the ward/unit where, valuing team support and the desire for this to develop, higher standards of care are felt to be delivered with a quality of team working together. Examples from the data include phrases like, "Actually working with someone you know and trust and rely on makes it better, just work together, makes a rubbish shift better" (3rd July 2013), and "good team support…come together as a team" (25th July 2013). There is the visible challenge of "Wanted to have done more" (10th March 2014), and "Elephant in the room is the pressure causing lower standards" (23rd May 2013), and yet "Will care for you regardless of what you throw at me" (16th December 2013).

I argue that there is increased trust in small familiar teams, wellbeing seen in relationship and support. As I have contended, developing a process of reflective practice to nurture a new broader understanding of wellbeing in healthcare has provided them with space to tell their own story. It is space to re-find their team connection and the invaluable nature of support and shared goal. This is within *their* team space, in the context of their own work challenges within their own immediate professional community. This is holistic, relational and contextual.

Holistic, relational and contextual chaplain

This project includes describing the model of the chaplain as reflective companion, human and vulnerable, the "empty handed" (Swift, 2009, p.175),

"welcoming guest" with "mutual hospitality" (Walton M., 2012, p.226). I want to argue further for this ministry as a priest/chaplain in this context.

Moving towards developing a process, a reflective practice for nurturing wellbeing using the 'conversation in community' of the HCPs, this is not a product but a gathering of people to reflect together in order to nurture something holistic and relational in the context of their own community. As has been described, the chaplain brings a background in theological reflection, tools for deep self-discovery, as well as the training and experience in pastoral and spiritual care. The secularist critics of chaplains label them as solely religious (for example claiming that supporting a religion affects the level of pastoral care received such as in Evans, 2012) and so fail to see the generic and non-proselytising presence. The chaplain is alongside, to facilitate the discovery that, through anyone's own reflections, one may be able to interpret experiences in the face of acute challenge, to "give sacramental recognition to moments of personal crisis" (Swift, 2009, p.167). This means using the skill of one able to notice change and transformation of any kind.

It is the visible, accessibility, connectedness, the holistic, relational, contextual presence that is offered in this pastoral ministry. This connects with the public accessibility and openness of the chaplain frequently approached in the hospital by those who would never usually seek contact with clergy. Chaplaincy is an example of public theology, the interface between religion and the public space, where theology is a way of thinking, where for chaplains "theology is their expertise" (Pattison, 2015, p.111). It is "a source of nurture, challenge and insight" (Pattison, 2015, p.126) with religion as an example and not an end in itself. This does not deny the integrity of the faith of the chaplain but invites the insights of faith to provide the language of

transformation and change, journeying and discovery. It is a unique model of ministry and personal human one. I wanted to explore chaplaincy's pastoral care of staff in the light of the reflecting and learning from human experience that this provides.

The chaplaincy role has been described (Chapter 4) as filling gaps meaning the chaplain's "vacuum identity" where they "fill a void rather than offering a well-defined service" (de Vries et al, 2008, p.25), or more positively where spiritual care could be called "a way of naming absences and recognizing gaps" (Swinton and Pattison, 2010, p.226). I see the contribution of the chaplain in this project as filling the gap as a developing presence in a holistic, relational and contextual role with HCPs.

As has been seen (Chapter 1), a future place for chaplains has been identified in being there for difficult conversations or decision making as "key support agents for patients, families and staff during such times" (Timmins et al, 2017, p.16). However, I argue that this is part of the contribution the chaplain makes in the reflective space of this project, as the data exposes the challenge of the HCPs professional concerns, the need for space to re-find team connection and shared support, to be re-energized to fulfil their own deep need to contribute to providing care but with job satisfaction. The chaplain in the context of this project is already helping HCPs live fully, supporting the claim that chaplains have the skills to develop staff's ability "to fruitfully inhabit" healthcare's challenging world (Swinton and Kelly, 2015, p.184), as part of developing reflection to nurture a more holistic, relational and contextual wellbeing.

A conclusion – towards developing reflective practice for wellbeing

My contribution to knowledge and practice is in reflective practice, healthcare and chaplaincy. I have challenged the healthcare understanding of wellbeing from 'health' to describing it more broadly as 'holistic, relational and contextual'. The limitation of NHS policies and strategies is that they advocate the 'health' model with emphasis on physical health and fitness for work. The onus is on individual staff to care for themselves and to respond to institutional programmes. I have explored wider wellbeing literature including from anthropology, sociology and national statistics. This revealed that wellbeing, in addition to health, is an organic multi-layered experience. It connects with feelings, one's living and working culture, being with people with a shared goal. It connects with one's relationships and one's sense of contribution to life. This means wellbeing is *also* related to the whole person, their relationship with those around them, and in their context at that time.

I have contributed in moving towards developing a reflective praxis that nurtures this new wider understanding and its value in the healthcare culture. Hitherto, reflective practice works predominantly for professional development and education. Reflective practice is a story-telling way of learning from experience and a source of personal growth. However, the complex and hard-to-recall reflective cycles can make it limiting as a day to day method. There *is* evidence of forms of facilitated reflective practice in healthcare, and a call for the NHS to become a more reflective culture. Group reflection though is most visibly in the larger community of the institutional gatherings. Contrastingly I have shown the holistic, relational and contextual aspects of wellbeing, valued and revealed by reflecting in the immediate community of one's HCP team.

Developing the work of Kolb (1984), my HELP Wellbeing Reflection Cycle builds on his view of the learning process that combines work development

and personal integrity (Kolb, 1984, p.225). Advancing the combination of work and self, my emphasis however is on the human wellbeing of HCPs in the work environment. I further contribute by seeing the potential for this process as their self-help tool, encouraging the HCPs, over time, to self-facilitate their own reflective groups.

My project responds to Rolfe (2104) who advocates the regular use of 'reflection-in-action' in nursing. He urges them to "reflect on-the-spot, in the here-and-now" so that their professional clinical practice is "a continuous and spontaneous interplay between thinking and doing" (Rolfe, 2014, p.1180). I have developed this in a reflective process, in-the-moment, exploring their experience, to nurture the wider sense of wellbeing. This develops 'reflection-in-action' in the important contextual nature of the HCP 'team' community. Using my simple memorable HELP Wellbeing Reflection Cycle, reflecting together as a team and with a chaplain as co-reflector, they have as 'living human documents' been the source of their own learning. Reflecting on the use of this cycle and HCPs response, it is evident from the data that they value the space to tell their story, to talk, expressing it in powerful terms of space "to remind us we're humans" (22nd August 2013) and "energized to be professional again" (11th October 2013).

I reveal the HCPs' contribution to the wider interpretation of wellbeing in three ways. Linking the 7 data themes, I then re-examined the wellbeing theme with a 'wellbeing definition tool', and recognized the shape of the RPWs, the way in which they respond to the HELP cycle. The first 6 themes from the data reveal the issues on which they reflected included professional concerns and human connection issues, valuing the space to reflect together and shared team support. These are consistent with the description of 'multi-layered, whole person in relation to their community and context' as a developed interpretation of wellbeing.

The ‘wellbeing definition tool’ I created, to compare the data with the literature, also consistently showed an understanding broader than health. This research theme shows that the HCPs reflect on the multi-layer of professional and personal issues, feelings about themselves and their team, the work culture and job satisfaction, and their own position with this context.

The shape of the RPWs, following the four stage HELP cycle, similarly was consistent with this interpretation. Firstly, they reflect on professional concerns, secondly the human connection, thirdly valuing their colleagues and then valuing space to reflect. This also reveals the reflections of the whole person, in their relationships and in their context.

Developing the wider understanding of wellbeing does not deny the ‘health’ model but argues for a broader, more compassionate awareness of the human experience. Returning to the literature, I have drawn attention to national statistics data where wellbeing relates to one’s quality of life (ONS, 2014). While naturally a healthy life is deeply desirable, wellbeing brings a greater richness to it, connecting with one’s whole life, with one’s local and wider society. I offer to national healthcare the wider understanding of wellbeing, that also relates to the whole person, to people in relation to others and in their context. I show the value of creating provision for reflective space to nurture it, in the care of healthcare professionals.

I develop the practice of chaplains as co-reflector with HCPs and in encouraging HCPs to self-facilitate their own reflective groups. Broadly speaking the focus in today’s chaplaincy naturally includes developing the role in today’s NHS. The recent review (Timmins et al, 2017) sees the potential for chaplains to be valuable in supporting staff at crisis points. I argue that my research contributes to addressing this in the chaplaincy role in today’s healthcare crisis. Exploring the motifs of ‘creating space’, of the “empty handed” (Swift, 2009, p.175), “welcoming guest” with “mutual hospitality”

(Walton M., 2012, p.226) of the human chaplain, I reflect that these are significant in my chaplaincy practice as a reflective companion. This is a ministry that makes sufficient space to recognize the personal human story and sees the human connection. It means being real, being genuine in one's own openness and presence. This ministry makes space to put aside one's own story in order to hold the story of the other and as both host and guest in the reflective space.

Within practical theology's sense of 'human experience as a source of discovery' and the 'pastoral encounter' of chaplaincy, I have seen the reflective space with HCPs as a pastoral encounter. This is not only with the chaplain but as the HCP team themselves. I have argued the need for this vital reflective space to nurture their holistic and relational wellbeing in their own small community and context. Using a listening and journeying model from 21st century Benedictine spirituality that builds an 'inner sanctuary', I have mirrored this thesis as a building of space for listening, by listening.

This project is a contribution to reflective practice, healthcare and chaplaincy. As this reflective process continues to develop, the challenge is helping institutional moves towards acknowledging the value of this deeper understanding of wellbeing and of this kind of reflective space. Seeing beyond this research project, it is an exciting and challenging contribution for development in a wider constituency both in and beyond healthcare.

Appendix A

Participant Information Sheet 'Reflective Practice and Wellbeing'

You are invited to take part in a research project investigating the use of reflective practice for wellbeing in the self-care of healthcare professionals.

The study is being conducted by The Rev'd Sacha Pearce, Chaplain at Derriford Hospital Plymouth, as part of his Doctor of Professional Studies in Practical Theology at the University of Chester. Plymouth Hospitals NHS Trust is the sponsor as well and has also reviewed the study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please do not hesitate to ask Sacha if there is anything that is not clear, or if you would like any more information. Do please feel free to take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?

The purpose of the study is to explore the development and incorporation of reflective practice in the healthcare professionals' regular working pattern for the wellbeing of each of them and their team.

Most healthcare professionals have some experience of using reflection in their training and on courses for their professional development but this project suggests that by taking a familiar reflective cycle (eg Gibbs, 2008; Johns, 2009) and re-wording it, it may be possible to use it in the healthcare professional team as their own self-sustainable regular tool for a greater sense of wellbeing.

Why have I been asked to take part in this study?

You have been asked to participate in this research because you are a healthcare professional working in a team involved in any one of the diverse areas of work in this hospital.

Do I have to take part?

The choice to take part in this study is completely yours. If you decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. During the reflective workshops or interview, you are not under any obligation to contribute, or reply to any questions you feel uncomfortable answering, and you can leave the workshop or interview at any time. Please feel free to contact Sacha to discuss any questions or concerns you may have before deciding to take part.

What will happen if I take part?

If you decide to take part, you will be given this information sheet to keep and asked to sign the consent form. This will give your consent for Sacha Pearce to include anonymously the reflections you share with others present at the reflective workshops. For *only half of the participants and the ward/unit manager*, this will also provide the opportunity to arrange a personal and private interview at a time and place that is convenient for you, inviting different people at the start and then at 6 and 12 month stages.

The reflective workshops will last approximately 20 minutes and will meet monthly over the period of a year. At an interview, which will last approximately 30 minutes, you would be asked to discuss informally your view of reflective practice for wellbeing in healthcare.

The interview will be guided by both Sacha and your personal views. With your permission, the interview will be recorded, and transcribed. You will have the opportunity to review the transcript (the written version of the interview) to ensure it is an accurate and faithful record of the interview. You are free to withdraw from any further involvement, at any stage.

What are the possible risks or disadvantages of taking part?

There have not been any risks or disadvantages identified to you taking part in this study. Everyone involved will be reminded of the continued availability of either Sacha or any other chaplain for confidential reflection one-to-one on any matter whether personal or professional, as part of the normal chaplaincy provision for staff, patients and relatives, regardless of participation or non-participation in this research.

What are the possible benefits of taking part?

As a healthcare professional you will have the opportunity to further develop use of reflective practice for your own wellbeing as well as that of your work team. You may welcome the opportunity to discuss and share your experiences in relation to your personal and professional life. By taking part, you are helping to understand the possibilities for use of reflective practice in the care of the whole person.

What if something goes wrong?
If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact:

Prof. Robert Warner, Dean of Humanities, University of Chester, Chester, CH1 4BJ 01244 511980

Will my taking part in the study be kept confidential?

All information which is collected related in any way to you during the course of the research will be kept strictly confidential so that only Sacha carrying out the research will have access to such information. He will be facilitating the reflective workshops as well as identifying any staff who may feel interested in doing so, although Sacha will be participating in the reflective workshops even if someone else is facilitating. He will be conducting all the interviews with those identified as taking part in that particular way. Sacha will transcribe all the interviews and read the transcripts which will be anonymised. If you take part in the reflective workshop or interview, he will be using extracts from field notes and transcripts when presenting the research and when publishing the research findings.

Who is researching and funding this project?

The project is part of Sacha's doctoral study and must be undertaken within his professional practice. His course fees are in part funded by the Diocese of Exeter, from an endowment trust used for higher degrees, and the remainder by himself. The research will be carried out by Sacha Pearce.

Who can I contact for further information?

If you would like more information about the research before you decide whether or not you would like to take part, please do not hesitate to contact:

The Rev'd Sacha Pearce, Trust Team Chaplain, Department of Pastoral and Spiritual Care, Derriford Hospital, Plymouth, PL6 8DH
01752 792022 (internal 52022) pager (076595) 89355 sacha.pearce@nhs.net

Thank you very much for your interest in this research.

Appendix B

Title of Project:

Reflective practice for wellbeing
in the self-care of healthcare professionals.

Name of Researcher:
The Rev'd Sacha Pearce
Trust Team Chaplain
Department of Pastoral and Spiritual Care,
Derriford Hospital, Plymouth,
PL6 8DH
01752 792022 (internal 52022)
sacha.pearce@nhs.net

Please initial box

1. I confirm that I have read and understood the participant information sheet, dated ……., for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my care or legal rights being affected. ☐

3. I understand that the research records of this study may be looked at by authorised individuals from the Sponsor for the study, UK Regulatory Authorities or the Independent Ethics Committee in order to check that the study is being carried out correctly. I give permission, provided that strict confidentiality is maintained, for these bodies to have access to my research records for the above study and any further research that may be conducted in relation to it. ☐

4. I agree to take part in the above study. ☐

Name of Participant:

Date:

Signature:

Sacha Pearce (Chief Investigator)

Date:

Signature:

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